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ABSTRACT

One of the changes experienced during the past decade has been the occurrence of human-caused disasters. With the rise in the number of such complex events, the Center for Mental Health Services has updated this training manual to assist mental health administrators and workers in developing the training components of crisis counseling. This manual introduces the trainer to the Crisis Counseling Program model, the scope and limits of the program, and elements required for effective service design and delivery. It presents essential information on how the disasters affect children and adults; the importance of tailoring the program to fit the community; descriptions of effective disaster mental health interventions; and strategies for preventing and managing worker stress. The manual contains the following sections: (1) "Background and Overview"; (2) "Responses to Disaster"; (3) "Disaster Reactions of Potential Risk Groups"; (4) "Stress Prevention and Management"; (5) "Setting up Disaster Mental Health Services Training"; (6) Comprehensive Training Course Outline"; and (7) "Additional Training Needs and Options." (Contains 56 references.) (JDM)

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Training Manual

FOR MENTAL HEALTH AND HUMAN SERVICE WORKERS IN MAJOR DISASTERS

ED 459 383

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Training Manual

FOR MENTAL HEALTH AND HUMAN SERVICE WORKERS IN MAJOR DISASTERS

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PREFACE

Since 1974, the Center for Mental Health Services (CMHS) and its predecessor agency, the National Institute of Mental Health, has administered the Crisis Counseling Assistance and Training Program, in coordination with the Federal Emergency Management Agency (FEMA). The Crisis Counseling Program provides supplemental funding to States for short-term crisis counseling services to victims of Presidentially declared disasters. The Crisis Counseling Program includes a training component for direct service staff and other disaster service workers to ensure that appropriate services are provided to the community.

Published in 1978, this training manual was the first publication to originate from the program. The primary purpose of this edition is to provide an overview of substantive concepts to assist mental health administrators, planners, and trainers in developing the training component of crisis counseling projects. This edition has been extensively revised to reflect wisdom and knowledge gathered from 25 years of disaster mental health experience.

One of the significant changes America has experienced during the past decade has been the occurrence of human-caused disasters. With the rise in number of complex technological and terrorist events, we recognize the need to emphasize that the practical applications of this manual can be expanded to disasters and emergencies of all types.

One of the challenges of the program is the need to educate human service managers and mental health professionals that the Crisis Counseling Program model differs significantly from the traditional mental health model. Disaster mental health is a specialized service which requires distinct training. The skills, knowledge, and attitudes required for disaster mental health and crisis counseling are quite different from those needed in therapeutic, clinical mental health services. This manual introduces the trainer to the Crisis Counseling Program model, the scope and limits of the program, and elements required for effective service design and delivery.

The manual details specific guidelines on how disasters affect children, adults, and older adults, the importance of tailoring the program to fit the community, descriptions of effective disaster mental health intervention, and strategies for preventing and managing worker stress. It also includes a comprehensive training course (Section 6) with eleven different activities which can be modified to the phase of the disaster response

and tailored to current and anticipated needs of the community and program staff. Overheads and educational information have been specifically designed and formatted for immediate use by the trainer.

With the increase in number and complexity of disaster events, there is one factor that remains constant in determining the effectiveness of disaster mental health response and recovery—preparedness. Crisis counseling program services are most effective when there is an existing plan in place for rapid mobilization, response, and implementation of disaster mental health services.

FEMA provided funding to CMHS for revision of this manual as part of the continuing effort by both agencies to assist communities in achieving the goal of disaster mental health response and recovery planning. It is our hope that administrators, managers, and trainers will take advantage of this resource before disaster strikes to ensure that the most effective and appropriate crisis counseling services are provided to disaster survivors.

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SECTION 1

Background and Overview

Mental health intervention has become a valued dimension of immediate and long-term disaster response. Psychological recovery is recognized as a focus for relief efforts, along with repairing homes and rebuilding bridges. Emergency responders, disaster workers, and community members now receive mental health support following most large-scale disasters. Mental health professionals have readily stepped into the disaster milieu to provide counseling, debriefing, school interventions, case management, and consultation.

Legislative authority is given to the President under Section 416 of The Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988 (Public Law 100-707) to provide training and services to alleviate mental health problems caused or exacerbated by major disasters. The Act reads as follows:

> *Crisis Counseling Assistance and Training. The President is authorized to provide professional counseling services, including financial assistance to State or local agencies or private mental health organizations to provide such services or training of disaster workers, to survivors/victims of major disaster in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath.*

The Crisis Counseling Assistance and Training Program (commonly referred to as the Crisis Counseling Program) is managed by the Federal Emergency Management Agency (FEMA) in cooperation with the Center for Mental Health Services (CMHS).

Purpose of the Manual

While each disaster and community is unique, States face similar challenges as they mobilize the resources to provide post-disaster mental health services. Disaster mental health providers, program planners, and administrators must quickly acquaint themselves with "the basics" of disaster mental health to be able to design and deliver services that are effective. A primary purpose of this Manual is to present an overview of essential information including: how disasters affect children, adults and older adults, the importance of tailoring the program to fit the community, descriptions of effective disaster mental health interventions, and strategies for preventing and managing worker stress.

Another purpose of the Manual is to efficiently assist mental health administrators, planners, and disaster mental health trainers as they develop the training component of their crisis counseling project. Specific disaster mental health training is critical for all professional and paraprofessional personnel associated with a disaster mental health recovery program. This training can guide crisis counseling project development so that the wisdom gathered from twenty-five years of disaster mental health intervention is reflected in program services. A course outline for comprehensive disaster mental health training complete with overheads and handouts is in Section 6 of this Manual. *The overheads and handouts have been prepared for immediate use by the trainer.* Additional skill training for paraprofessional staff is described in Section 7.

Crisis Counseling Programs typically reach out to human service agencies and organizations in the community. Examples of service provider groups are disaster relief workers, health care professionals, church volunteers, senior center personnel, building permit inspectors, public assistance workers, food bank workers, day care staff, and agricultural extension employees. Crisis counseling staff provide educational presentations and materials on disaster mental health so that local human service workers are better equipped to serve their constituencies following the disaster. The material provided in this Manual, especially the summary tables and handouts, will be useful for human service workers. A description of training options for human service workers is included in Section 7.

Why Special Training?

Specific training is essential because post-disaster mental health services are significantly different from the work activities of most mental health professionals. A supportive conversation or a focused problem-solving session over a cup of coffee, at a feeding van, or at a town meeting are essential activities in disaster work. While a background in crisis intervention or critical incident stress is helpful, it does not prepare a mental health professional for the range of issues encountered in communities during the months following a disaster.

As public funding for mental health services has become primarily limited to serving those with serious and persistent mental illnesses, many mental health workers have become less experienced in dealing with the general population who may be coping with loss, disruption, and, in some cases, tragedy. Many outpatient psychotherapists, accustomed to the fifty-minute session in an office, find providing support services in people's homes or at shelters outside their comfort zone.

While case managers for people with mental illness and geriatric specialists are skilled at accessing resources and providing services outside an office, they benefit from training on disaster issues. Disaster mental health training builds on each mental health professional's existing strengths and experiences and provides a framework and specific interventions appropriate to the disaster context.

Newcomers to disaster work are impressed with the "alphabet soup" of agencies, centers, and services (e.g., DFO, EOC, ARC, FEMA, VOAD, SBA). For most, the bureaucratic context of disaster relief work is new, almost like operating in a different culture. Training provides the big organizational picture of disaster recovery, so that mental health workers can navigate in the new environment and utilize available resources.

Crisis Counseling Programs typically find that paraprofessionals from the affected communities can be highly effective community outreach workers. When paraprofessional workers represent the groups they are serving, for example, older adults, people of color, or people from different ethnic or cultural groups, they often readily gain access. Although these individuals may be "natural helpers" or "peer counselors" with other groups, specific training on disaster and mental health issues facilitates their integration into the program. In addition to specific disaster mental health training, paraprofessionals benefit from training and practice with basic counseling skills.

Occasionally, States will provide disaster mental health training for disaster mental health workers only, and not include those who will be providing clinical supervision or program administration. Disaster program experts emphatically concur that when all parties involved with a program have received training in disaster mental health, conflicts and misunderstandings that undermine program effectiveness can be avoided.

Overview of Resources

This Manual is intended as a companion resource to *Disaster Response and Recovery: A Handbook for Mental Health Professionals* (CMHS, 1994). While the Handbook provides practical information for planning and implementing disaster mental health services, this Manual focuses more on what workers need to know to provide those services. This Manual includes sections on how communities and survivors respond to disaster, potential at-risk groups, and stress management for staff. Recognizing the necessity for service providers to quickly develop competency in a new context, topic presentations are focused and brief. Additional readings are suggested in the text and listed at the end of sections. These have been selected because they provide synthesized research reviews and practical suggestions, and are readily available.

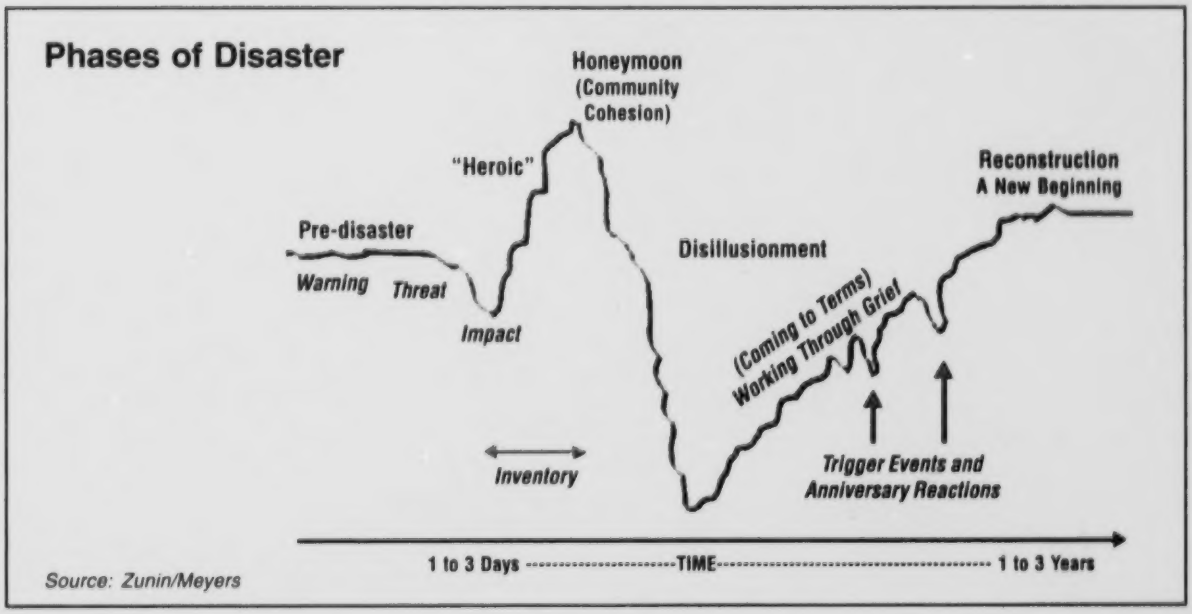
A comprehensive training course outline, which describes the specific skills, knowledge, and attitudes required for disaster mental health, is in Section 6. When the training content is not included in this manual, the trainer is directed, in most instances, to a chapter in the Handbook. Additional resources from the Center for Mental Health Services are extremely useful as well.

SECTION 2

Responses to Disaster

A survivor's reactions to and recovery from a disaster are influenced by a number of factors, some inherent and some malleable. These factors are depicted in the diagram below, and, as shown, contribute to recovery outcomes. The disaster event itself has characteristics, such as speed of onset or geographic scope, which generates somewhat predictable survivor responses. Each survivor has a combination of personal assets and vulnerabilities that either mitigate or exacerbate disaster stress. The disaster-affected community may or may not have pre-existing structures for social support and resources for recovery. Disaster relief efforts that effectively engage with survivors and the overall community promote recovery.

This section describes critical variables associated with each factor. The term "psychosocial" is often used to capture the breadth of effects of disaster on survivors. As shown in the diagram below, disasters unavoidably impact survivors both psychologically and socially. Disaster mental health program planners, administrators, and providers can more easily assess their own communities and design effective interventions when they have an appreciation for this "macro" view of interacting factors.



Characteristics of Disasters

Disasters are not uniform events. Each disaster, be it a flood, earthquake, hurricane, or human-caused disaster, has intrinsic unique elements. These elements have psychological implications for survivors and communities. The disaster characteristics discussed in this section are: natural vs. human causation, degree of personal impact, size and scope, visible impact/low point, and the probability of recurrence. Each of these, individually or collectively, has the potential for shaping and influencing the nature, intensity, and duration of post-disaster stress.

Natural vs. Human Causation

While there are divergent findings regarding whether natural or human-caused disasters produce greater overall psychological effects, there are clearly psychological reactions unique to each (Weisaeth,1994; Rubonis & Bickman,1991). In human-caused disasters such as bombings and other acts of terrorism, technological accidents, or airline crashes, survivors grapple with deliberate human violence and human error as causal agents. The perception that the event was preventable, the sense of betrayal by a fellow human(s), the externally focused blame and anger, and the years of prolonged litigation are associated with an extended and often volatile recovery period.

In true natural disasters, the causal agent is seen as beyond human control and without evil intent. For some, accepting mass destruction as "an act of God" is easier, whereas for others it can be more difficult. The world can temporarily seem to become unsafe with its potential for random, uncontrollable and devastating events (Yates, 1998).

In reality, there is a continuum between natural and human factors. Many disasters occur or are worsened through an interaction of natural and human elements (Green & Solomon, 1995). For example, damage from the natural event of flooding may be increased due to human factors such as inadequate planning, governmental policies, or faulty warning systems. An aircraft accident may result from an interaction of poor weather conditions and pilot error. Survivors experience reactions consistent with each dimension as they struggle with causal attributions.

Degree of Personal Impact

Researchers have consistently shown that the more personal exposure a survivor has to the disaster's impact, the greater his or her post-disaster reactions (Solomon & Green, 1992). Death of a family member, loss of one's home, and destruction of one's community exemplify high impact factors. In each of these, the intertwining of grief and trauma processes compound the effects and extend the duration of the recovery period for

many survivors (Kohn & Levav, 1990). High exposure survivors experience more anxiety, depression, sadness, post-trauma symptoms, somatic symptoms, and, in some studies, alcohol abuse.

Size and Scope of the Disaster

As with the degree of personal impact, a dose-response relationship between community devastation and psychological impact exists. When entire communities are destroyed, everything familiar is gone. Survivors become disoriented at the most basic levels. Researchers have found higher levels of anxiety, depression, post-traumatic stress, somatic symptoms, and generalized distress associated with widespread community destruction (Solomon & Green, 1992).

When some fabric of community life is left intact (e.g., schools, churches, commercial areas), there is a foundation from which recovery can occur. Social support occurs more readily when community gathering places remain. Survivors are then more able to continue some of their familiar routines. Family roles of provider, homemaker, or student are more able to be fulfilled when structures and institutions remain.

Visible Impact/Low Point

Most disasters have a clearly defined end point that signals the beginning of the recovery period. After a tornado, hurricane, or wildfire has passed through an area, the community sees the total extent of resulting physical destruction and begins the recovery and rebuilding process. The disaster threat is over and healing can begin.

However, in contrast technological events like nuclear accidents or toxic spills are "silent" disasters and do not show visual damage or have an observable "low point." The health consequences of increased risk for cancer and birth defects continue for decades (Green & Solomon, 1995; Berren et al., 1989). This prolonged impact period with no clear end impedes the recovery process. Survivors suffer the effects of chronic stress and anxiety due to the extended period of anticipation, fear, and threat (Davidson & Baum, 1994).

The end point of the disaster can be ambiguous in some natural disasters as well. Although an earthquake has its major impact, the aftershocks keep survivors worrying that "the big one is yet to come." Slow moving, repeat flooding, and related landslides may continue for months through a period of heavy rains. While there is visual physical damage to be reckoned with, it may be weeks or months before survivors feel that the disaster is truly over.

Probability of Recurrence

When the disaster has a seasonal pattern, such as hurricanes or tornadoes, survivors are concerned they will be hit again before the season ends. During the low-risk portion of the year, communities rebuild. Vegetation grows back and visual reminders of the disaster diminish. At the one-year anniversary, the reminder that the area is potentially at-risk again causes disaster stress and hypervigilance to resurface.

The immediate probability of recurrence is perceived as high following earthquakes and floods. The aftershocks following an earthquake or the increased risk of flooding due to ground saturation and damaged flood control structures following major floods keep many survivors anxious and preoccupied. In flood plain areas prone to repeat flooding, survivors can be kept in limbo regarding governmental buyouts, rezoning, or the rebuilding of their homes as local, State, and Federal agencies address jurisdictional and legislative issues. This can be especially threatening and anger inducing when the next year's flood season approaches and decisions and/or repairs have not yet been made.

These five characteristics of disasters—natural vs. human causation, degree of personal impact, size and scope, visible impact/low point, and the probability of recurrence—contribute to dynamics that have potential psychosocial implications. These characteristics further define the disaster event portrayed in the diagram at the beginning of this section. Now, the discussion will shift to the survivor's characteristics that can mitigate or elevate disaster stress outcomes.

Survivor/ "Person" Characteristics

A major disaster indiscriminately affects all who are in its path. Some disasters, such as a tsunami or landslide, may happen disproportionately to destroy wealthy people's shoreline or cliff-top view properties; whereas, another disaster, such as an earthquake or hurricane, may destroy poor people's structurally unsound housing. The disaster may affect thousands to millions of people in a densely populated urban area, or affect comparatively small numbers of people in a sparsely populated rural area.

Each survivor experiences the disaster through his or her own lens. The meaning the survivor assigns to the disaster, the survivor's inherent personality and defensive style, and the survivor's world view and spiritual beliefs contribute to how that person perceives, copes with, and recovers from the disaster. Experiences with losses or disasters may enhance coping or may compromise coping due to unresolved issues associated with those past events.

Having sufficient financial resources and being able to benefit from a social support network buffer the potentially devastating effects of a disaster and greatly assist the recovery process. An additional resilience factor includes the ability to tolerate and cope with disruption and loss. In contrast, vulnerability factors include preexisting health or emotional problems and additional concurrent stressful life events (McFarlane, 1996). In addition, cultural experience and ethnic background may facilitate or interfere with a survivor's ability to engage with disaster relief efforts.

Research findings are inconsistent with regard to the impact of gender and age on psychological outcomes. There is some indication that those in the forty to sixty age range may be more at risk because of the competing demands of child rearing, jobs, and caring for elderly parents (Green & Solomon, 1995). While single survivors may be more vulnerable than those who are married, increased marital conflict has been demonstrated following disasters. Refer to Section 3 for more information on the disaster reactions of potential risk groups.

Disaster Relief Efforts

When disaster relief efforts "fit" the community being served, survivors' access to assistance is enhanced. Information is available in native languages through print media, radio, and television. Relief workers are respectful of differences and work with trusted community leaders. Barriers are identified and addressed as every effort is made to connect survivors with resources for recovery.

While the above description is a goal, relief efforts may fall short. Disaster mental health workers may identify survivor groups who are not receiving services or recognize incompatibilities between the relief operation and the disaster-affected community. When individual survivors are unable to access services because of their limitations, disaster mental health workers may assist the survivor with overcoming personal or institutional barriers.

The relationships depicted in the Phases of Disaster diagram (page 5) shift over time. The experiences and needs of survivors and the community are different in the first week following the disaster compared with those at three months. Disaster relief efforts, including mental health programs, must maintain awareness of and accommodate to the time-based phases of disaster response (Tassey et al., 1997).

Phases of Disaster

Both community and individual responses to a major disaster tend to progress according to phases. An interaction of psychological processes with external events shapes these phases. Examples of significant time-related external events are the closure of the emergency response phase,

the damage assessment of one's personal residence, or receiving financial determinations. The following represents a compilation of phase lists developed by different disaster experts. These particular phases have been selected and described because of their relevance to disaster mental health planners and workers in providing ongoing disaster recovery assistance.

Warning or Threat Phase

Disasters vary in the amount of warning communities receive before they occur. For example, earthquakes typically hit with no warning, whereas, hurricanes and floods typically arrive within hours to days of warning. When there is no-warning, survivors may feel more vulnerable, unsafe, and fearful of future unpredicted tragedies. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

When people do not heed warnings and suffer losses as a result, they may experience guilt and self blame. While they may have specific plans for how they might protect themselves in the future, they can be left with a sense of guilt or responsibility for what has occurred.

Impact Phase

The impact period of a disaster can vary from the slow, low-threat buildup associated with some types of floods to the violent, dangerous, and destructive outcomes associated with tornadoes and explosions. The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial effects.

Depending on the characteristics of the incident, people's reactions range from constricted, stunned, shock-like responses to the less common overt expressions of panic or hysteria. Most typically, people respond initially with confusion and disbelief and focus on the survival and physical well-being of themselves and their loved ones. When families are in different geographic locations during the impact of a disaster (e.g., children at school, adults at work), survivors will experience considerable anxiety until they are reunited.

Rescue or Heroic Phase

In the immediate aftermath, survival, rescuing others, and promoting safety are priorities. Evacuation to shelters, motels, or other homes may be necessary. For some, post-impact disorientation gives way to adrenaline induced rescue behavior to save lives and protect property. While activity level may be high, actual productivity is often low. The capacity

to assess risk may be impaired and injuries can result. Altruism is prominent among both survivors and emergency responders.

The conditions associated with evacuation and relocation have psychological significance. When there are physical hazards or family separations during the evacuation process, survivors often experience post-trauma reactions. When the family unit is not together due to shelter requirements or other factors, an anxious focus on the welfare of those not present may detract from the attention necessary for immediate problem-solving.

Remedy or Honeymoon Phase

During the week to months following a disaster, formal governmental and volunteer assistance may be readily available. Community bonding occurs as a result of sharing the catastrophic experience and the giving and receiving of community support. Survivors may experience a short-lived sense of optimism that the help they will receive will make them whole again. When disaster mental health workers are visible and perceived as helpful during this phase, they are more readily accepted and have a foundation from which to provide assistance in the difficult phases ahead.

Inventory Phase

Over time, survivors begin to recognize the limits of available disaster assistance. They become physically exhausted due to enormous multiple demands, financial pressures, and the stress of relocation or living in a damaged home. The unrealistic optimism initially experienced can give way to discouragement and fatigue.

Disillusionment Phase

As disaster assistance agencies and volunteer groups begin to pull out, survivors may feel abandoned and resentful. The reality of losses and the limits and terms of the available assistance becomes apparent. Survivors calculate the gap between the assistance they have received and what they will require to regain their former living conditions and lifestyle.

Stressors abound—family discord, financial losses, bureaucratic hassles, time constraints, home reconstruction, relocation, and lack of recreation or leisure time. Health problems and exacerbations of pre-existing conditions emerge due to ongoing, unrelenting stress and fatigue.

The larger community less impacted by the disaster has often returned to business as usual, which is typically discouraging and alienating for survivors. Ill will and resentment may surface in neighborhoods as survivors receive unequal monetary amounts for what they perceive to be equal or similar damage. Divisiveness and hostility among neighbors undermine community cohesion and support.

Reconstruction or Recovery Phase

The reconstruction of physical property and recovery of emotional well-being may continue for years following the disaster. Survivors have realized that they will need to solve the problems of rebuilding their own homes, businesses, and lives largely by themselves and have gradually assumed the responsibility for doing so.

With the construction of new residences, buildings, and roads comes another level of recognition of losses. Survivors are faced with the need to readjust to and integrate new surroundings as they continue to grieve losses. Emotional resources within the family may be exhausted and social support from friends and family may be worn thin.

When people come to see meaning, personal growth, and opportunity from their disaster experience despite their losses and pain, they are well on the road to recovery. While disasters may bring profound life-changing losses, they also bring the opportunity to recognize personal strengths and to reexamine life priorities.

Individuals and communities progress through these phases at different rates depending on the type of disaster and the degree and nature of disaster exposure. This progression may not be linear or sequential, as each person and community brings unique elements to the recovery process. Individual variables such as psychological resilience, social support, and financial resources influence a survivor's capacity to move through the phases. While there is always a risk of aligning expectations too rigidly with a developmental sequence, having an appreciation of the unfolding of psychosocial reactions to disaster is valuable.

Key Concepts of Disaster Mental Health

The following guiding principles form the basis for disaster mental health intervention programs. Not only do these principles describe some departures and deviations from traditional mental health work; they also orient administrators and service providers to priority issues. The truth and wisdom reflected in these principles have been shown over and over again, from disaster to disaster.

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma—individual and community.
- Most people pull together and function during and after a disaster, but their effectiveness is diminished.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
- Disaster relief assistance may be confusing to disaster survivors. They may experience frustration, anger, and feelings of helplessness related to Federal, State, and non-profit agencies' disaster assistance programs.
- Most people do not see themselves as needing mental health services following a disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be uniquely tailored to the communities they serve.
- Mental health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of disaster.
- Social support systems are crucial to recovery.

(CMHS, 1994; See Chapter 1, page 1, for more information.)

Community Outreach

Outreach approaches that offer practical assistance with problem-solving and accessing resources are key to a successful program. Returning to the diagram at the beginning of this Section, "disaster relief efforts," as shown, include disaster mental health services. It is essential that those services have the flexibility to engage with diverse individual survivors and the varied elements within the community. Programs should establish a vital presence early in recovery, developing creative strategies to meet survivors where they are and bring them forward in their recovery process.

Most people who are coping with the aftermath of a disaster do not see themselves as needing mental health services and are unlikely to request them. People reacting to disasters tend to have little patience with implications that they are in need of psychological treatment. This is why terms like "psychotherapy" or "psychological counseling" are often rejected and terms like "assistance with resources" and "talking about disaster stress" are more acceptable.

Survivors who will be using program services are, for the most part, normal, well-functioning people who are under temporary emotional stress.

Disaster mental health workers must ***go to*** the survivors and not wait and expect that the survivors will come to them (Cohen, 1990). This means being visible in the disaster-affected neighborhoods, often going door-to-door to check-in with residents to see if they want assistance. Establishing relationships with community gatekeepers like corner store owners, or local cafe staff is important for referrals of survivors in need. Attending community gatherings at churches, schools, or community centers is useful for connecting with local residents and providing disaster mental health information. Besides these outreach approaches, educational materials that describe and emphasize the normalcy of reactions are of great benefit for disaster survivors. Educational outreach through the media—television, newspaper, radio, and community newsletters—reaches survivors whom other means might not contact. *Disaster Response and Recovery: A Handbook for Mental Health Professionals* provides extremely useful and detailed information about community outreach in a range of settings (CMHS, 1994).

Disaster mental health workers are most likely to find people struggling with the disruption and loss caused by the disaster. Disaster-related psychological symptoms warranting diagnosis are rare (Ursano, et al., 1995). People vary in the ability to recognize their own needs and in comfort level with asking for help. They may, for example, feel that it is personally degrading to request clothing or to seek an emergency loan. This reluctance can usually be overcome by personal contact with a caring person, who has the correct information and encourages the seeking of assistance.

Above all, disaster mental health programs must actively fit the disaster-affected community. Salient dimensions for consideration include: ethnic and cultural groups represented, languages spoken, rural or urban locales, values about giving and receiving help, and who and what the affected groups are most likely to trust. Access and acceptance is gained more quickly when disaster mental health programs coordinate and collaborate with local trusted organizations.

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SECTION 3

Disaster Reactions of Potential Risk Groups

Although there are many feelings and reactions people share in common following a disaster, there are also expressions that are more specifically influenced by the survivor's age, cultural and ethnic background, socioeconomic status, pre-existing physical, and psychosocial vulnerabilities. Disaster mental health workers are better prepared to design effective interventions when they have an understanding of how demographic and health factors interact with disaster stress.

This section describes groups commonly found within communities following a disaster and provides suggestions for disaster mental health interventions. Common issues, concerns, and reactions are also briefly presented in this section.

Common Needs and Reactions

First is a review of some thoughts, feelings, and behaviors common to all who experience a disaster:

- Concern for basic survival
- Grief over loss of loved ones and loss of valued and meaningful possessions
- Fear and anxiety about personal safety and the physical safety of loved ones
- Sleep disturbances, often including nightmares and imagery from the disaster
- Concerns about relocation and related isolation or crowded living conditions
- Need to talk about events and feelings associated with the disaster, often repeatedly
- Need to feel one is a part of the community and its disaster recovery efforts

Potential Risk Groups

Each disaster-affected community has its own demographic composition, prior history with disasters or other traumatic events, and cultural

representation. When disaster program planners review the groups impacted by a disaster in their community, consideration should be given to the following, as well as additional groups unique to the locale:

- Age groups
- Cultural and ethnic groups
- Socioeconomic groups
- People with serious and persistent mental illness
- Human service and disaster relief workers

The majority of survivors are resilient and with time can integrate their disaster experiences and losses and move on. However, survivors who have significant concurrent psychosocial, health, or financial problems are at greater risk for depression, anxiety, post-traumatic stress symptoms or an exacerbation of their pre-existing condition. When survivors have personally sustained severe disaster losses (e.g., death of a loved one, devastation of home and community), their reactions are more intensely expressed and over a longer period of time (Solomon & Green, 1992). This section includes a brief overview for each group. The disaster reactions described normally resolve over time with sufficient support and physical recovery. References for more detailed information are provided.

Age Groups

Each stage of life is accompanied by special challenges in coping with the aftermath of a disaster and age-related vulnerabilities to disaster stress. For children, their age and development determine their capacity cognitively to understand what is occurring around them and to regulate their emotional reactions. Children are more vulnerable to difficulty when they have experienced other life stresses in the year preceding the disaster, such as a divorce, a move, or the death of a family member or pet (Vogel & Vernberg, 1993). For adults, stress associated with family and home disruption, financial setbacks, and work overload predominate. For older adults, concerns regarding health, financial stability, and living independently become primary.

The age groups considered in this section are:

- Preschool (ages 1-5)
- Childhood (ages 6-11)
- Pre-adolescence and Adolescence (ages 12-18)
- Adults
- Older Adults

Reactions and problems vary depending upon the phase of the post-disaster period. Some of the problems discussed appear immediately; many appear months later.

Preschool (ages 1-5)

Small children view their world from the perspectives of predictability, stability, and the availability of dependable caretakers. Disruption in any of these domains causes distress. Preschool age children often feel powerlessness and fear in the face of a disaster, especially if they are separated from parents. Because of their age and small size, they are unable to protect themselves or others. As a result, they may feel considerable anxiety and insecurity.

In the preschool years, children generally lack the verbal and conceptual skills necessary to understand and cope effectively with sudden unexpected stress. They typically look to parents and older siblings as behavior models, as well as for comfort and stability. Research has shown that children's reactions are more related to how their family or caregiver is coping than the actual objective characteristics of the disaster itself (Green et al., 1991).

Children who have lost one or both parents are especially in need. Loss of a relative, a playmate, or a pet is also a disturbing event for children. They will need opportunities to express their grief. One of the major fears of childhood is abandonment, so children need frequent reassurance they will be cared for.

Preschoolers express their upset through regressive behaviors such as thumb sucking, bed-wetting, clinging to their parents, a return of fear of the dark, or not wanting to sleep alone. They often have sleep problems and frightening dreams. These problems are best understood as normal expressions of anxiety about the disruption of their familiar routines and previously secure worlds.

In the natural course of events, small children will try to resolve traumatic experiences by reliving them in their play activities. They may reenact the earthquake, flood, or tornado repeatedly. Children should be encouraged to verbalize their questions, feelings, and misunderstandings about the disaster so that adults can listen and explain. Relief of disaster fears and anxiety is attained through reestablishing the child's sense of security. Frequent verbal reassurance, physical comforting, more frequent attention, comforting bedtime rituals, and mealtime routines are helpful. As much as possible, young children should stay with people with whom they feel most familiar.

Childhood (ages 6 - 11)

School age children are developing the cognitive capacity to understand the dangers to family and environment inherent in disasters. They are more able to understand the disaster event and the mitigating role of disaster preparedness. This awareness can also contribute to preoccupation with weather and disasters, and fears about family members being killed or injured. School age children have a great need to understand what has happened and the concrete steps that they can take for protection and preparedness in the future.

Children often have special bonds with playmates or pets. When the disaster causes loss of significant others due to death or relocation, the child may grieve deeply. They experience the full range of human emotions, but may not have the words or means to express their internal experience. Adults can assist children to express these powerful emotions through talking, play, art, and age-appropriate recovery or preparedness activities.

School age children also manifest their anxiety through regressive behavior. Returning to behavior appropriate for a younger age is trying for parents, but serves an initially functional purpose for the child. These behaviors include: irritability, whining, clinging, fighting with friends and siblings, competing with younger siblings for parents' attention, or refusing to go to school. Bedtime and sleep problems are common due to nightmares and fearfulness about sleeping alone or in the dark.

Sometimes children's behavior can be "super good" at home, because they are afraid of further burdening their parents or causing more family disruption. They may show disaster stress at school through concentration problems, a decline in academic performance, aggression toward classmates, or withdrawal from social interactions. Some children may have somatic reactions and seek attention from the school nurse for stomach aches, headaches, nausea, or other complaints.

Pre-adolescence and Adolescence (ages 12 - 18)

This age group has a great need to appear competent to the world around them, especially to their family and friends. They struggle with the conflicts inherent in moving toward independence from parents on the one hand and the desire to maintain the dependence of childhood on the other. Approval and acceptance from friends are of paramount importance. Adolescents need to feel that their anxieties and fears are both appropriate and shared by their peers.

Disaster stress may be internalized and expressed through psychosomatic symptoms such as, gastrointestinal distress, headaches, skin problems, or vague aches and pains. Sleep problems such as insomnia, night terrors, or sleeping excessively may signal internal upset. Adolescents may turn to alcohol or drugs to cope with their anxiety and loss.

Social or school problems may also occur. Acting out or rebellious behavior may involve fighting with others, stealing, or power struggles with parents. Other adolescents may express their distress through withdrawal from friends and family and avoidance of previously enjoyed activities. School performance may decline. When the disaster causes major destruction of home and community, an older adolescent may postpone the developmental step of moving away from home.

Adults

Adults are focused on family, home, jobs, and financial security. Many are involved with caring for elderly parents as well. Pre-disaster life often involves maintaining a precarious balance between competing demands. Following a disaster, this balance is lost with the introduction of the enormous time, financial, physical, and emotional demands of recovery. Children in the family are in special need of attention and familiar routines, yet parents do not have enough hours in the day to accomplish all that is before them.

Over time, this stress overload can be manifested through physical symptoms of headaches, increased blood pressure, ulcers, gastrointestinal problems, and sleep disorders. Somatic reactions are especially present in those who are less able to experience and express their emotions directly. Cultural, gender-based, or psychological factors may interfere with emotional expression and seeking social support.

Emotional reactions often oscillate between numbness and intense expression. Anxiety and depression are common, as adults grapple with both anxiety about future threats and grief about the loss of home, lifestyle, or community. Anger and frustration about relief efforts abound, sometimes reflecting a displacement of the "less rational" anger that the disaster happened to them and was out of their control.

Older Adults

In the normal course of life, older adults typically have coped with losses prior to the disaster. They may have successfully adjusted to losses of employment, family, home, loved ones, or physical capabilities. For some, coping with these prior losses has strengthened resilience. For

others, the prior losses may have worn down the individual's reserves and the disaster is an overwhelming blow (Norris et al., 1994). As a result of the disaster, irreplaceable possessions such as photographs or mementos passed on through generations may be destroyed. Pets or gardens developed over years may be lost. Mental health workers must recognize the special meaning of these losses, if they are to assist with grieving.

Older adults living on limited incomes tend to reside in dwellings that are susceptible to disaster hazards due to the location and age of the buildings. Because of financial limitations and age, they may not be able to afford the repairs to their homes. Leaving familiar surroundings is especially difficult for those who experience deficits in hearing, vision, or memory, because they rely on known environmental cues to continue living independently.

Many older adults fear that if their diminished physical or cognitive abilities are revealed, they risk loss of independence or being institutionalized. As a result, they may under report the full extent of their problems and needs. They may continue living in damaged or unsanitary conditions, because they do not have the physical strength, stamina, or cognitive organizational ability to undertake disaster clean up. Disaster mental health workers must carefully assess the range and full extent of problems in living faced by the older survivor. Often, concrete practical assistance for recovery, stabilization, and engagement with appropriate resources allows the older adult to continue living independently.

A larger proportion of older persons, as compared with younger age groups, have chronic illnesses that may worsen with the stress of a disaster, particularly when recovery extends over months. They are more likely to be taking medications that need to be replaced quickly following a disaster. While older adults may be in more need of multiple services for recovery, they are often especially reluctant to accept help and what they perceive as "handouts." Disaster mental health programs can more quickly gain acceptance when they work closely with known, trusted organizations and employ older adults as outreach workers.

Disaster Reactions and Intervention Suggestions

Age Groups	*Behavioral Symptoms*	*Physical Symptoms*	*Emotional Symptoms*	*Intervention Options*
PRESCHOOL (1 - 5)	- Resumption of bed-wetting, thumb sucking - Clinging to parents - Fears of the dark - Avoidance of sleeping alone - Increased crying	- Loss of appetite - Stomach aches - Nausea - Sleep problems, nightmares - Speech difficulties - Tics	- Anxiety - Fear - Irritability - Angry outbursts - Sadness - Withdrawal	- Give verbal assurance and physical comfort - Provide comforting bedtime routines - Avoid unnecessary separations - Permit child to sleep in parents' room temporarily - Encourage expression regarding losses (i.e., deaths, pets, toys) - Monitor media exposure to disaster trauma - Encourage expression through play activities
CHILDHOOD (6 - 11)	- Decline in school performance - Aggressive behavior at home or school - Hyperactive or silly behavior - Whining, clinging, acting like a younger child - Increased competition with younger siblings for parents' attention	- Change in appetite - Headaches - Stomach aches - Sleep disturbances, nightmares	- School avoidance - Withdrawal from friends, familiar activities - Angry outbursts - Obsessive preoccupation with disaster, safety	- Give additional attention and consideration - Relax expectations of performance at home and at school temporarily - Set gentle but firm limits for acting out behavior - Provide structured but undemanding home chores and rehabilitation activities - Encourage verbal and play expression of thoughts and feelings - Listen to the child's repeated retelling of disaster event - Involve the child in preparation of family emergency kit, home drills - Rehearse safety measures for future disasters - Develop school disaster program for peer support, expressive activities, education on disasters, preparedness planning, identifying at-risk children

(Continued, next page)

Disaster Reactions and Intervention Suggestions (Continued)

Age Groups	*Behavioral Symptoms*	*Physical Symptoms*	*Emotional Symptoms*	*Intervention Options*
PRE-ADOLESCENCE AND ADOLESCENCE (12 - 18)	- Decline in academic performance - Rebellion at home or school - Decline in previous responsible behavior - Agitation or decrease in energy level, apathy - Delinquent behavior - Social withdrawal	- Appetite changes - Headaches - Gastrointestinal problems - Skin eruptions - Complaints of vague aches and pains - Sleep disorders	- Loss of interest in peer social activities, hobbies, recreation - Sadness or depression - Resistance to authority - Feelings of inadequacy and helplessness	- Give additional attention and consideration - Relax expectations of performance at home and school temporarily - Encourage discussion of disaster experiences with peers, significant adults - Avoid insistence on discussion of feelings with parents - Encourage physical activities - Rehearse family safety measures for future disasters - Encourage resumption of social activities, athletics, clubs, etc. - Encourage participation in community rehabilitation and reclamation work - Develop school programs for peer support and debriefing, preparedness planning, volunteer community recovery, identifying at-risk teens
ADULTS	- Sleep problems - Avoidance of reminders - Excessive activity level - Crying easily - Increased conflicts with family - Hypervigilance - Isolation, withdrawal	- Fatigue, exhaustion - Gastrointestinal distress - Appetite change - Somatic complaints - Worsening of chronic conditions	- Depression, sadness - Irritability, anger - Anxiety, fear - Despair, hopelessness - Guilt, self doubt - Mood swings	- Provide supportive listening and opportunity to talk in detail about disaster experiences - Assist with prioritizing and problem-solving - Offer assistance for family members to facilitate communication and effective functioning - Assess and refer when indicated - Provide information on disaster stress and coping, children's reactions and families - Provide information on referral resources

(Continued, next page)

Disaster Reactions and Intervention Suggestions (Continued)

Age Groups	*Behavioral Symptoms*	*Physical Symptoms*	*Emotional Symptoms*	*Intervention Options*
OLDER ADULTS	- Withdrawal and isolation - Reluctance to leave home - Mobility limitations - Relocation adjustment problems	- Worsening of chronic illnesses - Sleep disorders - Memory problems - Somatic symptoms - More susceptible to hypo- and hyperthermia - Physical and sensory limitations (sight, hearing) interfere with recovery	- Depression - Despair about losses - Apathy - Confusion, disorientation - Suspicion - Agitation, anger - Fears of institutionalization - Anxiety with unfamiliar surroundings - Embarrassment about receiving "hand outs"	- Provide strong and persistent verbal reassurance - Provide orienting information - Use multiple assessment methods as problems may be under reported (e.g., repeat observations, geriatric screening questions, discussion with family) - Provide assistance with recovery of possessions - Assist in obtaining medical and financial assistance - Assist in reestablishing familial and social contacts - Give special attention to suitable residential relocation - Encourage discussion of disaster losses and expression of emotions - Provide and facilitate referrals for disaster assistance - Engage providers of transportation, chore services, meals programs, home health, and home visits as needed

Cultural and Ethnic Groups

Disaster mental health programs must respond specifically and sensitively to the various cultural groups affected by a disaster. In many disasters, ethnic and racial minority groups may be especially hard hit because of socioeconomic conditions that force the community to live in housing that is particularly vulnerable. Language barriers, suspicion of governmental programs due to prior experiences, rejection of outside interference or assistance, and differing cultural values often contribute to disaster outreach programs' difficulty in establishing access and acceptance. Communities that take pride in their self-reliance are reluctant to seek or accept help, especially from mental health workers.

Cultural sensitivity is conveyed when disaster information and application procedures are translated into primary spoken languages and available in non-written forms. Intense emotions are typically experienced and expressed in a person's language of origin, so outreach teams that include bilingual, bicultural staff, and translators are able to interact more effectively with disaster survivors. Whenever possible, it is preferable

to work with trained translators rather than family members, especially children, because of privacy concerns regarding mental health issues and the importance of preserving family roles.

Cultural groups have considerable variation regarding views on loss, death, home, spiritual practices, use of particular words, grieving, celebrating, mental health, and helping. The role of the family, who is included in the family, and who makes decisions also varies. Elders and extended family play a significant role in some cultures, whereas isolated nuclear families are the decision-makers in others.

It is essential that disaster mental health workers learn about the cultural norms, traditions, local history, and community politics from leaders and social service workers indigenous to the groups they are serving. Program outreach workers and mental health staff are most effective when they are bilingual and bicultural. During the program development phase, establishing working relationships with trusted organizations, service providers, and community leaders is helpful. Being respectful, nonjudgmental, well informed, and following through on stated plans dependably are especially important for outreach workers.

Socioeconomic Groups

Many affluent, middle to upper middle class people live with a sense of security and see themselves as invulnerable to the devastation and tragedy associated with disasters. Because of their financial resources and life situations, they may have been protected from crises in the past, and have purchased insurance for "protection" in the future. They are more accustomed to planning and controlling life events, rather than unexpected overwhelming events controlling them. Shock, disbelief, self blame, and anger predominate in the hours and days following a major disaster, as the reality of losses, danger, and the work that lies ahead begins to sink in.

Higher income families may never have received assistance from social service agencies before. Accepting clothing, food, money, or shelter can be difficult and sobering. While they may need emergency assistance initially, they often do have social, financial, family, or other resources that engage quickly and buffer the disaster's impact.

Affluent families typically rely on known professionals for their support—their family physician, minister, or psychotherapist. Disaster mental health programs focus on educating local health care professionals and religious leaders about disaster stress, because these providers are most likely to encounter upper class survivors in need. *Psychosocial Issues for Children and Families in Disaster: A Guide for the Primary Care Physician* (CMHS, 1995) is an informative resource for training.

Recovery programs can also coordinate disaster mental health counseling and support groups through these known and trusted entities.

In contrast, low-income survivors have fewer resources and greater pre-existing vulnerability when disaster strikes. While they may have developed more crisis survival skills than the more protected upper class individuals, they often lack the availability of support and housing from family and friends and do not have insurance coverage or monetary savings. Without these, the recovery process is even more arduous and prolonged, and sometimes impossible. Federal and State disaster assistance programs are designed to meet serious and urgent needs. The intent of these programs is not to replace all losses. Uninsured, poor families may have unmet needs and should be referred to non-profit disaster relief organizations and unmet needs committees. If they are renters, they may be faced with unaffordable increases in rent after landlords have invested money to repair their properties. They may be dislocated to temporary disaster housing that is undesirable and removed from their social supports. Relocation may make transportation and getting to appointments more difficult.

Faced with these multiple challenges and assistance that falls short of solving the problems before them, low-income disaster survivors can feel overwhelmed. For those with limited reading and writing abilities, obtaining accurate information and completing forms is difficult. Disaster mental health workers are most effective when they provide concrete problem-solving assistance that facilitates addressing priority needs. Workers must be knowledgeable about the full range of community resources available to people of limited economic means and actively engage this resource network with those in need.

People With Serious and Persistent Mental Illness

Clinical field experience has shown that disaster survivors with mental illness function fairly well following a disaster, if essential services have not been interrupted. People with mental illness have the same capacity to "rise to the occasion" and perform heroically as the general population during the immediate aftermath of the disaster. Many demonstrate an increased ability to handle this stress without an exacerbation of their mental illness, especially when they are able to maintain their medication regimens.

However, some survivors with mental illness have achieved only a tenuous balance before the disaster. The added stress of the disaster disrupts this balance; for some, additional mental health support services, medications, or hospitalization may be necessary to regain stability. For individuals diagnosed with Post Traumatic Stress Disorder (PTSD),

disaster stimuli (e.g., helicopters, sirens) may trigger an exacerbation due to associations with prior traumatic events.

Many people with mental illness are vulnerable to sudden changes in their environment and routines. Orienting to new organizations and systems for disaster relief assistance can be difficult. Program planners need to be aware of how disaster services are being perceived and build bridges that facilitate access and referrals where necessary. Disaster mental health services designed for the general population are equally beneficial for those with mental illness; disaster stress affects all groups. In addition, when case managers and community mental health counselors have a solid understanding of disaster mental health issues, they are able to better provide services to this population following a disaster. *Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Major Disaster* provides a comprehensive discussion of planning, preparedness, and options for service delivery with this population (CMHS, 1996).

Human Service and Disaster Relief Workers

Workers in all phases of disaster relief, whether in law enforcement, local government, emergency response, or victim support, experience considerable demands to meet the needs of the survivors and the community. Typically, disaster workers are altruistic, compassionate, and dedicated people who occasionally have difficulty knowing when it is time to take a break from the operation. For many, the disaster response takes precedence over all other responsibilities and activities. The brochure, *Prevention and Control of Stress Among Emergency Workers—A Pamphlet for Workers*, is an excellent resource for both disaster relief workers and mental health providers (NIMH, 1987). This brochure highlights the importance of having a personal emergency preparedness plan, so that workers are assured that their families are safe while they devote themselves to disaster relief for the community.

Relief workers may witness human tragedy and serious physical injuries, depending on the nature of the disaster and their role. This contributes to the psychological impact of their work. In disasters in which there is a high level of exposure to human suffering, injuries, and fatalities, providing psychological support and interventions for workers is especially necessary. In addition, relief workers and first responders should be considered a target group for ongoing services during the course of the disaster mental health recovery program.

As some order returns to the community, many workers, particularly volunteers, return to their regular jobs. However, they may attempt to continue with their disaster work. Over time, the result of this overwork can be the "burn-out" syndrome. This state of exhaustion, irritability, and

fatigue creeps up unrecognized and can markedly decrease the individual's effectiveness and capability. These workers may be avoiding problems at home by working constantly. Disaster mental health workers should be on the lookout for workers whose coping resources have eroded due to their personal vulnerabilities and seemingly unrelenting workload. The next section in this manual, "Stress Prevention and Management," offers suggestions for identifying, educating, and intervening with those who may be having stress reactions and difficulty coping.

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SECTION 4

Stress Prevention and Management

Disaster mental health work is inevitably stressful at times. The long hours, breadth of survivors' needs and demands, ambiguous roles, and exposure to human suffering can affect even the most experienced mental health professional. The first "key concept" of disaster mental health states, "No one who sees a disaster is untouched by it." This combination of witnessing the disaster's destruction, working in an often chaotic environment, and having only limited resources available results in potentially stressful conditions.

These conditions require that planners and administrators integrate a comprehensive stress prevention and management plan into their mental health recovery programs. Too often, staff stress is addressed as an afterthought. Programs focus their efforts on survivors' "normal" reactions to traumatic events, and do not address the very same psychological processes that occur in staff as well. While disaster mental health work is personally rewarding and challenging, it also has the potential for affecting workers in adverse ways.

Preventive stress management focuses on two critical contexts: the organization and the individual (Quick et al., 1997). A disaster mental health program's organizational plan may initially be unclear or inadequate due to the rapid mobilization to address survivor needs. However, it is important that a functional plan and structure be developed quickly. Each worker providing services will be affected uniquely depending on his or her professional experience, personal history, and vulnerabilities. A pro-active approach for workers that teaches and encourages personal stress reduction strategies is essential. Adopting a preventive perspective allows programs to anticipate stressors and shape crises rather than simply reacting to them after they occur.

Organizational Context

Having an organizational structure and plan that builds in stress prevention can mitigate potential stress overload for staff. While these efforts may be time-consuming on the front end, the long-term benefits of reduced employee turnover and avoidance of thorny personnel issues, as well as increased productivity and program cohesion are well worth the efforts. The following five dimensions reflect necessary areas to

address when designing a strong program that prioritizes organizational health:

- Effective management structure and leadership
- Clear purposes and goals
- Functionally defined roles
- Team support
- Plan for stress management

Individual Context

Psychologically healthy and well-balanced individuals are best equipped to implement and maintain an effective disaster mental health recovery program. Programs can build in supports and interventions to ensure that the majority of their staff will be functioning in the "healthy and balanced" range. As community needs change over time, so will workers' stress management intervention needs. Listed below are four skill building areas to address when designing the staff stress management component of a program:

- Management of workload
- Balanced lifestyle
- Strategies for stress reduction
- Self awareness

Stress Prevention and Management Methods

The following charts present suggestions for organizational and individual stress prevention for immediate and long-term response time frames. Suggestions for the immediate response phase may be applicable for the long-term response phase as well. Approaches for eliminating and minimizing stressors and stress reactions are included. Since each disaster and mental health response has different elements, program planners will need to tailor the following to their own locale, resources, and disaster.

Organizational Approaches for Stress Prevention and Management

Dimension	*Immediate Response*	*Long-term Response*
EFFECTIVE MANAGEMENT STRUCTURE & LEADERSHIP	- Clear chain of command and reporting relationships - Available and accessible clinical supervisor - Disaster orientation provided for all workers - Shifts no longer than twelve hours with twelve hours off - Briefings provided at beginning of shifts as workers exit and enter the operation - Necessary supplies available (e.g., paper, forms, pens, educational materials) - Communication tools available (e.g., cell phones, radios)	- Full-time disaster-trained supervisors and program director with demonstrated management and supervisory skills - Clear and functional organizational structure - Program direction and accomplishments reviewed and modified as needed
CLEAR PURPOSE & GOALS	- Clearly defined intervention goals and strategies appropriate to assignment setting (e.g., crisis intervention, debriefing)	- Community needs, focus and scope of program defined - Periodic assessment of organizational health and service targets and strategies - CMHS Program Guidance guidelines integrated into service priorities - Staff trained and supervised to define limits, make referrals - Feedback provided to staff on program accomplishments, numbers of contacts etc.
FUNCTIONALLY DEFINED ROLES	- Staff oriented and trained with written role descriptions for each assignment setting - When setting is under the jurisdiction of another agency (e.g., Red Cross, FEMA), staff informed of their role, contact people, and expectations	- Job descriptions and expectations for all positions - Participating disaster recovery agencies' roles understood and working relationships with key agency contacts maintained
TEAM SUPPORT	- Buddy system for support and monitoring stress reactions - Positive atmosphere of support and tolerance with "good job" said often	- Team approach that avoids a program design with isolated workers from separate agencies - Informal case consultation, problem solving and resource sharing - Regular, effective meetings with productive agendas, personal sharing, and creative program development - Clinical consultation and supervision - In-service training appropriate to current recovery issues provided

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Organizational Approaches for Stress Prevention and Management (Contin.)

Dimension	*Immediate Response*	*Long-term Response*
PLAN FOR STRESS MANAGEMENT	- Workers' functioning assessed regularly - Workers rotated between low, mid, and high stress tasks - Breaks and time away from assignment encouraged - Education about signs and symptoms of worker stress and coping strategies - Individual and group defusing and debriefing provided - Exit plan for workers leaving the operation: debriefing, reentry information, opportunity to critique, and formal recognition for service	- Education about long-term stresses of disaster work and the importance of ongoing stress management - Program checklist including organizational and individual approaches and implementation plan - Plan for regular stress interventions at work and meetings (see next chart) - Extensive program phase down plan: timelines, debriefing, critique, formal recognition, celebration, and assistance with job searches

Individual Approaches for Stress Prevention and Management

Dimension	*Immediate Response*	*Long-term Response*
MANAGEMENT OF WORKLOAD	- Task priority levels set with a realistic work plan - Existing workload delegated so workers not attempting disaster response and usual job	- Planning, time management, and avoidance of work overload (e.g., "work smarter, not harder") - Periodic review of program goals and activities to meet stated goals - Periodic review to determine feasibility of program scope with human resources available
BALANCED LIFESTYLE	- Physical exercise and muscle stretching when possible - Nutritional eating, avoiding excessive junk food, caffeine, alcohol, or tobacco - Adequate sleep and rest, especially on longer assignments - Contact and connection maintained with primary social supports	- Family and social connections maintained away from program - Exercise, recreational activities, hobbies, or spiritual pursuits maintained (or begun) - Healthy nutritional habits pursued - Overinvestment in work discouraged

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Individual Approaches for Stress Prevention and Management (Contin.)

Dimension	*Immediate Response*	*Long-term Response*
STRESS REDUCTION STRATEGIES	- Reducing physical tension by taking deep breaths, calming self through meditation, walking mindfully - Using time off for exercise, reading, listening to music, taking a bath, talking to family, getting a special meal to recharge batteries - Talking about emotions and reactions with coworkers during appropriate times - Cognitive strategies (e.g., constructive self talk, restructuring distortions)	- Relaxation techniques (e.g., yoga, meditation, guided imagery) - Pacing self between low and high stress activities, and between providing services alone and with support - Talking with coworkers, friends, family, pastor, or counselor about emotions and reactions
SELF-AWARENESS	- Early warning signs for stress reactions recognized and heeded (see following section) - Acceptance that one may not be able to self-assess problematic stress reactions - Over identification with survivors' grief and trauma may result in avoiding discussing painful material - Vicarious traumatization or compassion fatigue may result from repeated empathic engagement (Figley, 1995; Pearlman, 1995)	- Exploration of motivations for helping (e.g., personal gratification, knowing when "helping" is not being helpful) - Understanding differences between professional helping relationships and friendships - Examination of personal prejudices and cultural stereotypes - Recognition of discomfort with despair, hopelessness, and excessive anxiety that interfere with capacity to "be" with clients - Recognition of over identification with survivors' frustration, anger, and hopelessness resulting in loss of perspective and role - Recognition of when own disaster experience or losses interfere with effectiveness - Involvement in opportunities for self exploration and addressing emotions evoked by disaster work

Signs and Symptoms of Worker Stress

Thus far, the focus of this section has been to describe methods for preventing and mitigating staff distress in a disaster mental health recovery program. The signs and symptoms of worker stress are also important to discuss, as early recognition and intervention are optimal. Educating supervisors and staff about signs of stress enables them to be on the lookout and to take appropriate steps. When programs emphasize stress recognition and reduction, norms are established that validate early intervention rather than reinforcing the more common (even though we know better) "worker distress is a sign of weakness" perspective.

Common Disaster Worker Stress Reactions

Psychological and Emotional

- Feeling heroic, invulnerable, euphoric
- Denial
- Anxiety and fear
- Worry about safety of self and others
- Anger
- Irritability
- Restlessness
- Sadness, grief, depression, moodiness
- Distressing dreams
- Guilt or "survivor guilt"
- Feeling overwhelmed, hopeless
- Feeling isolated, lost, or abandoned
- Apathy
- Identification with survivors

Cognitive

- Memory problems
- Disorientation
- Confusion
- Slowness of thinking and comprehension
- Difficulty calculating, setting priorities, making decisions
- Poor concentration
- Limited attention span
- Loss of objectivity
- Unable to stop thinking about the disaster
- Blaming

Behavioral

- Change in activity
- Decreased efficiency and effectiveness
- Difficulty communicating
- Increased sense of humor
- Outbursts of anger, frequent arguments
- Inability to rest or "letdown"
- Change in eating habits
- Change in sleeping patterns
- Change in patterns of intimacy, sexuality
- Change in job performance
- Periods of crying
- Increased use of alcohol, tobacco, or drugs
- Social withdrawal, silence
- Vigilance about safety or environment
- Avoidance of activities or places that trigger memories
- Proneness to accidents

Physical

- Increased heartbeat, respiration
- Increased blood pressure
- Upset stomach, nausea, diarrhea
- Change in appetite, weight loss or gain
- Sweating or chills
- Tremors (hands, lips)
- Muscle twitching
- "Muffled" hearing
- Tunnel vision
- Feeling uncoordinated
- Headaches
- Soreness in muscles
- Lower back pain
- Feeling a "lump in the throat"
- Exaggerated startle reaction
- Fatigue
- Menstrual cycle changes
- Change in sexual desire
- Decreased resistance to infection
- Flare-up of allergies and arthritis
- Hair loss

(CMHS, 1994)

As with disaster survivors, assessment hinges on the question of "How much 'normal stress reaction' is too much?" Many reactions listed are commonly experienced by disaster workers with limited job effects. However, when a number are experienced simultaneously and intensely, functioning is likely to be impaired. Under these circumstances, the worker should take a break from the disaster assignment for a few hours at first, and then longer if necessary. If normal functioning does not return, then the person needs to discontinue the assignment.

Clinical supervisory support is essential when a disaster worker's personal coping strategies are wearing thin. Counseling support involves exploring the meaning for the worker of the disaster stimuli, prior related experiences and vulnerabilities, and personal coping strategies. Suggestions can be made for stress reduction activities. Usually, stress symptoms will gradually subside when the worker is no longer in the disaster relief environment. However, if this does not occur, then professional mental health assistance is indicated.

Rewards and Joys of Disaster Work

Most staff find helping survivors and their communities following a major disaster to be enormously rewarding. Disaster mental health workers witness both gut wrenching grief and sorrow and the power of the human spirit to survive and carry on. To assist people as they struggle to put their lives back together is fundamentally meaningful. At the close of the long-term mental health recovery programs, staff often describe their participation as the most challenging and personally satisfying of their careers.

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SECTION 5

Setting Up Disaster Mental Health Services Training

To be an effective disaster mental health worker, one must be flexible, easily able to establish rapport, respectful of differences among people, and tolerant of ambiguity and confusion. Not everyone is suited to the varied rigors of disaster work. In the initial stages of program implementation, mental health recovery program administrators must recruit and select a cadre of mental health professionals and paraprofessionals to serve their communities effectively, if one does not already exist. Administrators seeking guidelines and suggestions may refer to Chapter 2, "Selection and Training of Disaster Mental Health Staff" in *Disaster Response and Recovery: A Handbook for Mental Health Professionals* (CMHS, 1994).

Participation in disaster mental health training prepares program staff for the unique organizational, procedural, emotional, and environmental aspects of disaster work. While new staff undoubtedly have relevant skills from their prior professional activities, disaster mental health work presents most with some significantly different challenges. The overwhelming response of mental health professionals after disaster mental health training is, "I didn't know how useful this would be!"

Effective training combines lecture presentations, films, skills practice, self-awareness exploration, group discussion, and experiential learning. Participants are exposed to case scenarios and videotapes that simulate disaster situations, so they are able to explore their own reactions and achieve some stress-inoculation prior to assignment.

The training process is not designed to be a "debriefing" for those who personally suffered disaster losses. If it is necessary to involve staff who are also disaster survivors, they should participate in a supportive group debriefing session prior to the training and be individually assessed. Staff and program supervisors may find that their personal disaster reactions interfere with their functioning as disaster mental health workers. Survivor staff members should be cautioned about their increased vulnerability and closely monitored and supported by supervisors.

Initial Start-up Training

In the immediate aftermath of the disaster, administrators must rapidly identify and deploy staff. If a disaster-trained group of available mental health professionals does not already exist, then training becomes a priority. Even those with prior disaster mental health training need to be oriented to the current disaster and response operation. An initial four to eight-hour start-up training should be offered quickly and repeated as new staff come on board.

The accompanying pamphlet *Field Manual for Mental Health and Human Service Workers in Major Disasters* (CMHS, Rev. ed. in press) to this Manual also provides a practical overview and "how to" information. It is a valuable pocket guide for ready-reference in the field.

Comprehensive Disaster Mental Health Training

Comprehensive training typically occurs after the majority of staff have been hired and toward the end of the immediate disaster response phase. This may be 3-6 weeks after the disaster. Depending on program implementation and the timing of hiring staff, it may be most appropriate to provide comprehensive training twice—once at 3-6 weeks and again after 3-4 months. Training should be mandatory for all staff and volunteers who will be involved with the program, including supervisors and administrators.

This comprehensive training serves a number of functions. In addition to providing information about people's reactions to disaster and the range of disaster mental health interventions, training goals are to:

- Develop group cohesion and a program identity
- Orient staff to organizations involved with disaster response and recovery
- Establish norms and procedures for staff stress management
- Communicate the goals, mission, and philosophy behind the Crisis Counseling Program
- Present the plan and rationale for on-going supervision, case consultation, and in-service training
- Communicate program policies and procedures with regard to organizational structure, financial management, and program activity data collection

While the initial training is a "start-up" training, the comprehensive training can be viewed as a program "kick off." This can be a time that old and new program staff convene to form a collaborative and cohesive work team. Procedures for program monitoring, staff stress management, and the long-term program structure have been established and can be further implemented through the training.

Paraprofessional outreach workers will need training beyond the comprehensive disaster mental health training. They bring a range of life and work experiences that enriches the program. However, it is important that they participate in specific training on counseling skills, intervention guidelines, and when and how to make referrals (see Section 7). Providing this training is helpful prior to the comprehensive disaster mental health training, so paraprofessional staff have a broader framework for integrating the information. Training should be ongoing so that skills can be developed and honed over time. Close and supportive supervision is helpful during the early phase of the program. While it is important that paraprofessional staff participate in skill-building training, inadvertently encouraging a division between program staff would be destructive. Program administrators must address the need for additional paraprofessional training without compromising group cohesion and team support.

Setting Up the Training

The training should be held in a comfortable setting with audio-visual equipment suitable for the room and size of the group. Although less than thirty participants is an ideal size for training, logistics may dictate that the group be larger. Under those circumstances, having additional small group facilitators and trainers to review and give feedback on role-plays enhances the depth of the training.

Selecting the Trainer

In the immediate response to the disaster, the importance of rapidly training and deploying disaster mental health staff may require the program to involve a local mental health professional with no disaster experience as the trainer. While having prior disaster experience is preferable, it may not be practical. Alternate relevant background experience might include: crisis intervention in a mental health center, critical incident stress management with emergency service workers, experience in community-based settings, breadth in professional and clinical work, and effectiveness as an educator. This Manual and *Disaster Response and Recovery: A Handbook for Mental Health Professionals* (CMHS, 1994) will enable the trainer to become oriented quickly.

The comprehensive training must be taught by a mental health professional with disaster experience and, ideally, experience in a nine-month crisis counseling grant. Not only should the trainer have the requisite knowledge to present the material, but also he or she should be an engaging presenter and highly skilled with group processing of emotions. The trainer must be able to model skills, as well as teach them. Trainers coming from outside the geographic area of the disaster will need to become familiar with the local disaster—its impact, population groups

affected, damage assessment information, dynamics of the disaster having psychological implications, and relief efforts to date. Grant applications, bulletins or summaries from the State's emergency management department or from FEMA, videotapes of news coverage, and summary newspaper articles can be useful sources for gathering this background information.

The comprehensive training program could include different trainers with special expertise in certain topics, such as children or older adults. These trainers should also be familiar with long-term disaster recovery so that their presentations are immediately relevant to the needs of the participants. Typically, a representative from FEMA and/or the State department of emergency management will present the portions of the training on state and Federal disaster assistance programs.

When the program is serving particular cultural or ethnic groups, presentations by representatives of those groups should be included in the training. These representatives may be community leaders, social service agency workers, or educators on cultural sensitivity. Staff members from those groups may contribute to the training process.

Who Should Attend?

When individuals who have not been oriented to disaster mental health issues administer programs, unnecessary conflicts and inconsistencies arise. Therefore, it is essential that all paraprofessional and mental health professional staff, program administrators, and supervisors associated with the program attend the training.

Frequently representatives from FEMA, CMHS, the local department of emergency management, or the American Red Cross attend the training. These individuals bring valuable information and perspective. Their presence and participation convey the importance of the joint effort of disaster recovery. Program administrators need to balance the need for a cohesive group training vs. including people from adjunct agencies and referral sources. As will be discussed in Section 7, the training may be designed so that a broader group is included in the first day and the program staff only in the remaining days.

SECTION 6

Comprehensive Training Course Outline

A comprehensive training course for disaster mental health recovery program staff, both mental health professionals and paraprofessionals, is described in this section. The session may require 2.5 - 4 days, depending on the depth and scope of the material presented. It is assumed that the trainer has prior disaster mental health experience, particularly with a long-term recovery program, has participated in a formal disaster mental health training session, and has independently studied disaster mental health readings and research. Also, the trainer needs to be adept at group processing of emotions and to be able to model excellent listening and empathic skills.

This program design has eleven major content areas, organized into "Activities" each requiring from thirty minutes to 2.5 hours. Each of the eleven Activity descriptions has five sections:

1. Topics Covered
2. Objectives
3. Time Required
4. Materials Required
5. Procedures

Most of the Activity descriptions include a balance of lectures, overheads, films, and experiential exercises. Activity 10: Stress Prevention and Management Section includes a number of group exercises that can be used when the trainer wants to vary the pace of the training. Examples of overheads, some handouts, and references for the films are included at the end of this section. Content for the lectures is either briefly included under "Procedures" or the trainer is directed to other sections in this manual, NIMH and CMHS publications, or other resources. While these documents provide "the basics," the trainer is encouraged to develop his or her own disaster stories and case examples to bring the training to a more personal and specific level.

Since this comprehensive training may be held anytime between three to four months after the disaster, the lecture content for each topic needs to be adapted to the phase of the disaster response and

tailored to the current and anticipated needs of the program staff. Alternate suggestions for later training sessions are included in the "Procedures" descriptions. In addition, the material should be presented in a way that is most suitable for the participants. For some groups, including more findings from psychosocial research is appropriate, whereas, for others focusing on nuts-and-bolts skill building is indicated.

The trainer is also encouraged to become knowledgeable about the current disaster. Reading the State's crisis counseling grant application can be useful for this purpose. Local information can be woven into the training and used as examples throughout the more general discussions of disaster issues. Although this training is divided into eleven discrete Activity areas, an effective trainer remains flexible and seizes "teaching moments" as they emerge from the group discussion.

This training plan is intended as primarily suggestive, providing the trainer with a format and some ideas that have worked successfully with other groups. Experienced trainers will have developed their own approaches to many of the topics. The content areas presented in this plan need to be covered in a comprehensive training course. For some groups and trainers, it may make sense to change the order of Activity areas or to break out portions of the Activity suggestions and then to return to the rest at a later point in the training. Content experts may conduct portions of the training (e.g., a representative from FEMA, a resource person from an ethnic group).

Course Overview

The following overview lists course objectives, training content areas, and suggested time requirements. The training content is not further divided into daily agendas, because it is assumed that the trainer's preferences, the group's composition and needs, and the local disaster dynamics will dictate this level of specificity.

Course Objectives

- Understand human behavior in disaster, including factors affecting individual responses to disaster, phases of disaster, "at risk" groups, concepts of loss and grief, postdisaster stress, and the disaster recovery process.
- Understand the organizational aspects of disaster response and recovery, including key roles, responsibilities, and resources; local, State, Federal, and voluntary agency programs; and how to link disaster survivors with appropriate resources and services.
- Understand the key concepts and principles of disaster mental health, including how disaster mental health services differ from

traditional psychotherapy; the spectrum and design of mental health programs needed in disaster; and appropriate sites for delivery of mental health services.

- Understand how to intervene effectively with special populations in disaster, including children, older adults, people with disabilities, ethnic, and cultural groups indigenous to the area, and the disenfranchised or people living in poverty with few resources.
- Provide appropriate mental health assistance to survivors and workers in community settings, with emphasis on crisis intervention, brief treatment, post-traumatic stress strategies, age-appropriate child interventions, debriefing, group counseling, support groups, and stress management techniques.
- Provide mental health services at the community level, with emphasis on casefinding, outreach, mental health education, public education, consultation, community organization, and use of the media.
- Understand the stress inherent in disaster work and recognize and manage that stress for themselves and with other workers (CMHS, 1994).

Overview of Comprehensive Training Course

	Content Area	*Suggested Time Required*
Activity 1:	**INTRODUCTION**	**1 hour**
Activity 2:	**DISASTER INFORMATION**	**1.5 hours**
Activity 3:	**ORGANIZATIONAL DISASTER RESPONSE NETWORK**	**1.5 hours**
Activity 4:	**PHASES OF REACTIONS TO DISASTER**	**.5 hour**
Activity 5:	**ADULT REACTIONS TO DISASTER**	**2 hours**
Activity 6:	**DISASTER MENTAL HEALTH INTERVENTIONS**	**4 hours**
Activity 7:	**CHILDREN IN DISASTER**	**2.5 hours**
Activity 8:	**SPECIAL POPULATIONS IN DISASTER**	**2 hours**
Activity 9:	**PLANNING WORKGROUPS**	**1.5 hours**
Activity 10:	**STRESS PREVENTION AND MANAGEMENT**	**2 hours**
Activity 11:	**PROGRAM IMPLEMENTATION**	**1.5 hours**

DISASTER MENTAL HEALTH TRAINING COURSE OUTLINE

ACTIVITY 1

Materials Required

- *Training handout*
- *Name tags*

INTRODUCTION

Topics Covered

- Distribution of materials
- Welcome and brief overview of training
- Introductions
- Training objectives, agenda, materials

Objectives

1. To introduce trainers and participants
2. To review training objectives, agenda, and values underlying training
3. To begin group building through participant disclosure
4. To model listening skills

Time Required

1 hour

Procedure

1. ***Distribute Materials:*** Distribute name tags, handout materials, booklets, etc.
2. ***Welcome and Brief Overview:*** Give a welcoming statement, brief overview of the training day, and discuss logistics (e.g., breaks, lunch, phones, bathrooms, etc.). State that group participation is encouraged and that any and all questions are welcome.
3. ***Introductions:*** Trainer introduces self, highlighting disaster and other related experience. Participants introduce themselves giving name, agency affiliation, current job, location in the disaster program, description of experience with current disaster and/or prior disasters, and expectations/

ACTIVITY 1: Introduction
(Continued)

desires for the training. Trainer models active listening, may briefly bring out points relevant to disaster mental health.

4. ***Training Goals and Objectives:*** Review the goals and objectives for training (see Handout #1). Trainer addresses participants' stated expectations, commenting on what will and will not be included in the training and how other training needs may be met.

5. ***Agenda and Training Techniques:*** Review overall training agenda and discuss training techniques (e.g., short lecture, discussion, films, small group exercises, and role-plays). Discuss rationale and values underlying techniques (e.g., people learn by doing, disaster work affects providers personally so sharing and support is important, balance learning new content with developing new skills).

ACTIVITY 2

DISASTER INFORMATION

Topics Covered

- Definition of disaster
- Classification of disasters
- Types of disasters
- Current disaster data

Objectives

1. To acquaint participants with characteristics of disasters and their implications for mental health effects
2. To increase understanding of factors in the current disaster that may contribute to disaster stress in local population groups
3. To provide orientation to current disaster—its scope, nature of impact, damage assessment data, populations affected, and disaster response efforts

Time Required

1.5 hours

Materials Required

- *Training handouts*
- *Overheads*
- *Video of news coverage of current disaster (if one is not available, then video involving similar type of disaster), maps showing disaster-affected areas*

Procedure

1. ***Definition of a Disaster:*** Present a definition of disaster (see Overhead #1). Discuss how disasters are different from individual traumas because they involve entire communities and frequently also strain social support systems.
2. ***Characteristics of Disasters:*** Using Overhead #2, describe characteristics of disasters and their potential for psychological and community effects. Focus presentation on characteristics of the current disaster. Section 2 of this manual provides information.
3. ***Types of Disasters:*** Discuss types of disasters with reference to current disaster (see Overhead #3).
4. ***Description of the Current Disaster:*** Provide overview of information about current disaster including census information and populations affected, geographic areas affected, damage assessment data, and overview of disaster's impact and early relief efforts.

ACTIVITY 2: Disaster Information *(Continued)*

Show video of news coverage of current disaster. These are usually available from local TV stations and are extremely useful for both eliciting participants' own disaster experiences and orienting participants to the events that have occurred.

5. ***Processing Trainees' Reactions to the Disaster:*** Depending on the size of the group, facilitate a small or large group discussion focusing on questions like: What came up for you as you watched this film? What reactions might you expect the people who experienced this disaster to have? What particular aspects of this disaster would you expect to be related to psychological effects? What do you anticipate will be the difficulties/challenges for this community in recovery? For those of you who directly experienced this disaster, what was it like to see this film?

   If there is a subgroup of participants that personally experienced the disaster, try using a "fishbowl" technique. The "personally experienced" group forms an inner circle and discusses their experiences with the trainer while the rest of the participants form an outer circle and listen. This is not intended to be a "debriefing," but is more for informational purposes. This also provides an opportunity for the trainer and/or program supervisors to continue assessing if there are staff members who may be too involved in their own recovery process to be able to assist others effectively.

   Display disaster photographs, newspaper articles, and maps. This can be a group activity if some staff have been involved from the beginning. It can also give them an opportunity to describe their experiences while educating new staff.

ACTIVITY 3

ORGANIZATIONAL DISASTER RESPONSE NETWORK

Topics Covered

- Federal, State, local, and volunteer agencies involved in disaster response
- Disaster declaration process
- Glossary of abbreviations
- Local response and key resources

Objectives

1. To acquaint participants with local FEMA, State department of emergency management, and CMHS representatives who, if available, can present much of this section
2. To orient participants to the organizational context of disaster work and the role of the Crisis Counseling Program and disaster mental health workers in that context
3. To inform participants of the chronology of events involved in the disaster declaration process
4. To increase knowledge of local resources, contacts and how to access them

Time Required

1.5 hours

Procedure

1. ***Organizational Aspects of the Disaster:*** When FEMA and State department of emergency management representatives are available, they can usually conduct much of this section. It is also beneficial for participants to become acquainted with them and have faces and names to associate with some of the new and unfamiliar agencies. Briefly review the information and charts in Chapter 3, "Organizational Aspects of Disaster," in *Disaster Response and Recovery: A Handbook for Mental Health Professionals* (CMHS, 1994). Disaster mental health workers need to understand the "big" picture of the organizational players and can use Chapter 3 as a resource for specifics.

Materials Required

- *Training handouts*
- *Handouts from FEMA or State department of emergency management on local resources, phone numbers, and addresses*

ACTIVITY 3: Organizational Disaster Response Network
(Continued)

2. ***Federal, State, and Local Disaster Response and Recovery Activities:*** Present a chronology of disaster response and recovery activities including aspects like evacuations, shelters, road or bridge closures, and the local disaster declaration process and responsible agencies. Tailor the presentation to the current phase in the disaster response so that participants are acquainted with the history, as well as who the current key players are and what the current phase-related recovery activities are. If it is early in the disaster response and the American Red Cross is active, a presentation by a Disaster Mental Health or a Family Services volunteer can be informative about current community reactions and needs.
3. ***Speaking the Disaster Lingo/Defining Acronyms:*** A glossary of acronyms can be found at the end of Chapter 3 (CMHS, 1994). A similar list can be developed for the local disaster with the involved local, State, and Federal agencies.

ACTIVITY 4

PHASES OF REACTIONS TO DISASTER

Topics Covered

- Community reactions to disaster over time
- Phase-related psychological reactions

Objectives

1. To acquaint participants with the developmental sequence of community and individual responses
2. To introduce the concept that mental health interventions need to be relevant to the phase of community and individual response

Time Required

30 minutes

Procedure

1. ***Phases of Community Reactions to a Disaster:*** Describe each of the six phases of community reactions to disaster. See discussion in Section 2 of this manual. Use Overhead #4.
2. ***Phases of Psychological Reactions to a Disaster:*** Using Overhead #5, discuss psychological reactions as they relate to each phase. Use case examples to provide depth and enhance learning. While discussing the graph, also emphasize that survivors are individual and unique in their reactions and some may not experience much emotion or have delayed reactions, while others may be overwhelmed by one emotion (e.g. self doubt, fear). People typically move forward and backward through the "graph;" the healing process is not a uniform progression through stages. Participants typically value the simplicity of the graph, but also need to be cautioned that it is only generally descriptive.

Materials Required

- *Training handouts*
- *Overheads*

ACTIVITY 5

ADULT REACTIONS TO DISASTER

Topics Covered

- Film depicting adult reactions
- Participant self-reflection
- Physical, emotional, cognitive, behavioral reactions
- Trauma and grief processes

Time Required

2 hours

Procedure

1. ***Phase-Related Adult Reactions to Disaster:*** Show film as a follow-up to prior presentation on phase-related psychological reactions. Invite participants to note the reactions that they see survivors having in the film as well as their own feelings that may be touched by the film.

   Depending on the size of the group, discuss the film with the large group or break into smaller groups. First, facilitate discussion of the reactions that participants saw in the film and note how survivors' reactions may have changed with the passage of time. Discuss the interaction of disaster dynamics with survivors' reactions (e.g., length of warning, visual imagery, smells and sounds, threat to life). Invite participants to comment on these areas and then provide short lectures on salient aspects.

2. ***Participant Self-Reflection:*** Invite participants to explore what touched them personally as they watched the film—which survivors, what situations, and why they impacted them. Use this discussion to model acceptance and good listening skills, and to normalize that everyone is touched personally at times when doing disaster work. Continue with a lecture about the dynamics of countertransference (in very practical terms) and introduce the importance of self-care, stress management, staff consultation, and debriefing.

3. ***Types of Adult Reactions:*** Present physical, emotional, cognitive, and behavioral reactions to disaster using Overheads #6, 7, 8, and 9. Use case examples, examples from the film, examples from the current disaster, examples from the

Materials Required

- *Training handouts*
- *Overheads*
- *Film ("Faces in the Fire," "Beyond the Ashes," or "Disaster Psychology")*

ACTIVITY 5: Adult Reactions to Disaster *(Continued)*

participants' experiences, and research findings to bring these lists "alive." Review Section 3 of this manual. Depending on the timing of the training, focus more on reactions that are most relevant to current phase. Emphasize that reactions are "normal" responses for the majority of survivors and will resolve with time, support, information, and physical recovery. Activity 6 will address when reactions require additional professional attention. If the training is several months after the disaster, focusing on long-term recovery issues is appropriate (see Overheads #10 and 11).

4. ***Trauma and Grief Reactions:*** Discuss the overlay of trauma and grief reactions and processes for people who suffered both significant losses and the suddenness and fear associated with traumatic events. Recovery takes longer as these survivors must first move through their acute trauma reactions before working through the longer process of grieving losses (see Section 2). Because of the overlay of processes, the impact can be more psychologically devastating and the healing process more complex and difficult. If these issues are especially relevant for the current disaster, a focused in-service training at a later date would be indicated.

ACTIVITY 6

DISASTER MENTAL HEALTH INTERVENTIONS

Topics Covered

- Key concepts of disaster mental health
- Mental health interventions
- Assessment and referral
- Public education
- Group debriefing

Objectives

1. To orient participants to the "normalcy" of survivor populations and the "normalcy" of disaster stress reactions and when referrals are required
2. To assist mental health professionals to recognize the differences between disaster mental health work and more traditional office pathology-based psychotherapy
3. To describe specific intervention approaches with opportunities for role-play practice and observation

Time Required

4 hours

Materials Required

- *Handouts*
- *Overheads*
- *Sample public information brochures and materials*
- *Case scenarios*
- *Film*

Procedures

1. ***Key Concepts of Disaster Mental Health Service Delivery:*** Present "Key Concepts of Disaster Mental Health." Overhead #12 lists those that pertain specifically to service delivery. Section 1 in this manual and Chapter 1 in *Disaster Response and Recovery: A Handbook for Mental Health Professionals* (CMHS, 1994) provide more information and material for handouts.
2. ***Disaster Mental Health Versus Traditional Mental Health:*** Discuss how disaster mental health is different from traditional therapy. Emphasize aspects such as: service provider goes to the client rather than the client coming to the office, intervention is focused on problem-solving not achieving insight, and that terms like "mental health" or "counseling" are de-emphasized and terms like "assistance with solving problems" and "talking about disaster stress" are emphasized.

ACTIVITY 6: Disaster Mental Health Interventions
(Continued)

3. ***Disaster Mental Health Interventions and Post-Disaster Mental Health Interventions:*** Present Overheads #13 and #14. Chapters 6, 7, and 8 in *Disaster Response and Recovery: A Handbook for Mental Health Professionals* (CMHS, 1994) provide detailed information about assignment settings and specific approaches appropriate to each. Tailor the presentation to current disaster recovery settings, populations, and timing of interventions. Use concrete examples of appropriate interventions, such as, rapid assessment and triage, crisis intervention, group debriefing and town meetings, education on disaster stress and coping, information and referral, casefinding, community outreach, brief individual and group counseling, case management, and disaster preparedness.

4. ***Role-Play Exercise:*** Facilitate role-play practice exercise. Develop case scenarios that exemplify relevant situations and the approaches being taught. Trainer may set up a scenario and model the approach first and then divide participants into pairs or trios for role-play practice. Focus might be crisis intervention, structured supportive conversation about disaster experiences, or education about disaster stress and coping. Participants need to have their performance anxieties relieved while receiving feedback to enhance their learning. When presenting several types of interventions, go back and forth between describing and practicing.

5. ***Assessment and Referral:*** Provide clear guidelines for assessment and referral. While the listings of physical, emotional, cognitive, and behavioral reactions are considered "normal," in the extreme they are problematic and require further professional attention. Discuss manifestations of impairment and methods for intervention and referral. Participants will need a program procedure for case consultation and referral.

6. ***Community Education:*** Provide lecture on the significance of disseminating information on disaster stress reactions and suggestions for coping. Community education is an essential element of recovery programs. Show samples of brochures, posters, and articles from other programs. Demonstrate how to access examples via the Internet. Discuss how the program will develop and distribute materials if this hasn't been done already. If time allows, discussion could include accessing radio and television spots and coverage in local newspapers. This could also be an in-service training topic for later, or the focus of a task group.

ACTIVITY 6: Disaster Mental Health Interventions
(Continued)

7. ***Approach for Group Debriefing:*** Provide training on group debriefing approach and adaptations for community meetings or disaster workers. Use Overhead #15 to discuss components of a brief group intervention and how emphasis on the various components will change depending on the group, context, and purpose. Mental health professionals should be designated to conduct group sessions, as they require more experience and training. This could be a break out session in which mental health professionals focus on building group debriefing skills and paraprofessionals focus on basic counseling and listening skills.
8. ***Role-Play a Group Debriefing Intervention:*** Use a film clip of a case scenario to provide opportunity to further demonstrate and practice a group debriefing intervention. The trainer may enlist some participants to assume roles of community members following a disaster and then demonstrate the components of the intervention. As an alternative, a scenario from the film previously shown or a clip from the current disaster could be used. The trainer could also establish a "tag team" of facilitators so that participants can practice conducting portions of the group session.

ACTIVITY 7

CHILDREN IN DISASTER

Topics Covered

- Age-related reactions
- Age-appropriate interventions
- Coordination with the schools
- Coloring books and special projects

Objectives

1. To provide information about children's "normal" and problematic responses to disaster and family stress and methods for assessment
2. To assist participants in understanding developmental influences so they can appropriately design interventions
3. To identify strategies for working with the local schools and children's organizations
4. To provide examples of creative projects from other recovery programs

Time Required

2.5 hours

Materials Required

- *Training handouts*
- *Overheads*
- *Films ("Children and Trauma: The School's Response", "Hurricane Blues")*
- *Examples of coloring books, expressive and commemorative school projects (photos, posters, drawings, journals)*

Procedures

1. ***Children's Reactions to Disasters:*** Review background material in Section 3 of this manual and the *Manual for Child Health Workers in Major Disaster,* (second edition pending, CMHS, 2000). Recommended reading referenced at the end of Section 3 includes additional resource materials. Present lecture on children's reactions to disaster emphasizing developmental stages and the significant role of the family. Identify features of the current disaster that have salience for children (e.g., witnessing frightening events, high level of life threat, separation from family members, loss of school community). See Overheads #16, 17, and 18.
2. ***Risk Factors for Children:*** Discuss children's manifestations of stress from the current disaster observed by participants. Discuss interventions with children to date. Use Overhead #19 to discuss risk factors for children.

ACTIVITY 7: Children in Disaster *(Continued)*

3. ***Interventions:*** Present lecture on appropriate interventions with children for the various phases. See Handout #2 for an overview of strategies.

4. ***Demonstration of Children's Reactions and Interventions:*** Show "Children and Trauma." If the group has already seen this film and this is a later training session, "Hurricane Blues" depicts more long-term recovery issues for children and families. Discuss relevant aspects of the film and thoughts/reactions that arose for participants.

5. ***Systematic Program Strategy for Assessing the Needs of Children:*** If a high prevalence of serious post-disaster stress among children is anticipated because of the dynamics of the disaster (e.g., high death rate, large numbers of children witnessing grotesque scenes of destruction), a systematic program strategy for assessing children needs to be developed. Since children tend not to disclose the extent of their post-disaster stress to parents (Vogel & Vernberg, 1993), alternate strategies should be included. Several checklists have been developed for this purpose. Participants can practice through role-plays asking parents, teachers, and children assessment questions, or conducting a brief interview.

6. ***Psychological Tasks:*** Using Overhead #20, discuss the psychological tasks that a child must accomplish to integrate the disaster experience and move on. Discuss how age/developmental stage will affect the child's capacity to accomplish these tasks and how this affects intervention strategies.

7. ***School Systems:*** Discuss methods for developing collaborative relationships with the schools for local children affected by the disaster. Gaining access to the schools can be challenging, especially several months after the disaster. First, determine likely entry points (e.g., school nurses, counselors, teachers, PTA, principals, superintendent). Utilize program staff's and agency's contacts and relationships with school personnel.

   Determine what would be a good "angle" or service to facilitate a working relationship. These might be: referral resource for disaster high risk children and families, consultation/training with counselors and nurses, in-service training for teachers, or a presentation at a PTA meeting. The interventions listed on Handout #2 can be used for teacher training or mental health professional facilitated classroom

ACTIVITY 7: Children in Disaster *(Continued)*

interventions. FEMA (1991a and 1991b) has some useful publications on school interventions developed by California programs.

Other organizations serving children can be more accessible. Possibilities include: day care programs, YMCA/YWCA, 4-H, scout programs, church youth programs, community centers, or summer camps.

8. ***School and Community Projects:*** Display coloring books, expressive and commemorative school projects, and compilations of writings or drawings from different mental health recovery programs and communities. Engage participants to creatively brainstorm innovative project ideas for current disaster.

ACTIVITY 8

SPECIAL POPULATIONS IN DISASTER

Topics Covered

- Older adults
- Cultural and ethnic groups
- Low socioeconomic groups
- Persons with disabilities

Objectives

1. To identify special population groups affected by current disaster
2. To review unique issues associated with each potentially at-risk group
3. To understand how disaster stress may be experienced and expressed by each group

Time Required

2 hours

Procedures

1. ***Older Adults:*** Review Section 3, "older adults" portion and *Psychosocial Issues for Older Adults in Disasters: A Guide for Health and Mental Health Professionals* (CMHS, 1999). The chart in Section 3 can be used as a handout and basis for discussion. Also, see Handout #3.

   Show selected portions or all of "Voices of Wisdom." Use the film to raise issues and generate discussion of needs.

2. ***Cultural and Ethnic Groups:*** When there are particular ethnic or cultural groups affected by the disaster, staff must acquire cultural competency and earn acceptance with those groups. See Section 3 for a brief discussion of issues. Handout #4 provides some additional information. As mentioned previously, representatives from the group may assist with training. Community members may share their disaster experiences and insights about cultural sensitivity. Additional training on cultural issues and awareness may be provided as in-service training.

Materials Required

- *Training handouts*
- *Film "Voices of Wisdom"*

ACTIVITY 8: Special Populations in Disaster
(Continued)

3. ***Low Socioeconomic Groups:*** When people with low socioeconomic resources are involved in a disaster, they are frequently faced with immediate financial crisis. Section 3 briefly discusses these concerns. Staff need to learn generally about Federal, State, and local resources for all types of assistance, who to call, and how to refer.
4. ***People with Disabilities:*** Disabilities that involve difficulty with mobility, hearing or vision impairments, and dependence on special equipment or procedures can contribute to the survivor's sense of vulnerability and helplessness. Being unable to hear warnings, or physically leave one's home and having to be evacuated by strangers often is deeply distressing. People with disabilities may be especially anxious about future disasters and benefit from problem-solving discussions about disaster preparedness.

ACTIVITY 9

PLANNING WORKGROUPS

Topics Covered

- Program planning for special population groups

Objectives

1. To develop specific program strategy plans for addressing the disaster mental health needs of each group identified in Activity 8
2. To encourage team approach to program planning
3. To identify expertise and interest areas of staff relevant to special groups
4. To identify strategies for outreach, relationship building with community leaders and key agency resources, and group-sensitive interventions

Time Required

1.5 hours

Procedures

1. ***Identifying Special Populations:*** Identify groups requiring special program focus. Examples are children, older adults, people in institutions, people with disabilities, and cultural or ethnic groups. A workgroup might focus on training for human service workers in the community.
2. ***Special Population Workgroups:*** Establish "workgroups" of participants for each population group. Distribute task assignment handouts (See Handout #5). Give groups 45 minutes to discuss issues and brainstorm strategies and intervention ideas. Groups transcribe their ideas to flip chart paper for group presentation. Groups report their considerations and ideas and request input from the larger group.

   Trainer further comments on groups or issues raised (utilizing "teaching moments") and enthusiastically recognizes the work of each group.

   Trainer and/or program administrator discusses how the workgroup ideas will be addressed or incorporated into the program plan in the future.

Materials Required

For each group:

- *Handout*
- *Flip chart*
- *Pen*

ACTIVITY 10

STRESS PREVENTION AND MANAGEMENT

Topics Covered

- Stressors and worker stress
- Organizational and individual approaches
- Self awareness
- Stress reduction strategies

Objectives

1. To provide information regarding worker stress and burnout
2. To introduce and discuss specific organizational and individual approaches to prevent and mitigate stress
3. To enhance team support and group cohesiveness
4. To identify individual vulnerabilities to stress and personal prevention and management strategies

Time Required

2 hours (Exercises should be interspersed throughout the training course.)

Materials Required

- *Training handouts*
- *Overheads*
- *Flip chart*
- *Pens*

Procedures

1. ***Disaster Work Stressors:*** Discuss stressors inherent in disaster mental health work. Using Overhead #21, discuss the three potential sources of stress as they pertain to the timing of this training. Engage the group in identifying examples in each category.
2. ***Concept of Stress:*** Present the concept of "stress" as neither intrinsically good or bad. People experience stress when they start a new job, get married, go to a foreign country, take on a professional challenge, etc. At optimal levels, stress can enhance performance. When it is too much, it can erode well being and coping. Use Overhead #22 to illustrate that stress can be prevented and managed.
3. ***Symptoms of Worker Stress:*** Review list of symptoms of worker stress in Handout #6. Invite participants to identify symptoms that they have experienced with the current disaster, or in the past with other intensive human service

ACTIVITY 10: Stress Prevention and Management *(Continued)*

activities. Next, encourage them to list what coping or stress reduction strategies they used, and what was helpful. Divide participants into groups of three and invite them to discuss their responses to the above questions. This can be a good time for listening and paraphrasing skill practice as well, if that has previously been addressed in the course.

4. ***Coping Strategies:*** Generate a group list of coping strategies on the flip chart, by asking a member of each trio to report to the class. Model giving positive and encouraging feedback. Make the point that giving positive feedback and saying "thank you" often is a powerful group stress intervention.

5. ***Organizational and Individual Approaches to Preventing and Managing Stress:*** Using Overheads #23 and 24, present material included in Section 4 on organizational and individual approaches to prevent and manage stress. The charts provide specific examples of interventions. Stress reduction strategies generated in the previous exercise by the group can be used as examples as well. When discussing the "organizational approaches," the trainer or program administrator may describe methods that the current program is adopting. This also could be addressed in Activity 11. Throughout the presentation, encourage group participation, suggestions, and ideas.

6. ***Team Building:*** Facilitate team building exercise. First, have participants jot down their best team experiences (sports, club, service, job, etc.). Next, ask them to silently reflect on the characteristics of the team and the role they played on that team. Trainer lists characteristics on flip chart and summarizes with lecturette about what contributes to effective work teams.

   This next phase of the team building exercise may require that the work units form small groups. Adaptations will need to be made to allow for the size of the group. Discuss "principles of how we want to work together." Examples might be: we will encourage, initiate and participate in direct communication; we will discuss work issues with involved person as they occur; we will responsibly manage our time and workload; or we will treat each other with respect and consideration. First, participants write three to four principles that they'd like adopted. Then, the lists get read and combined so that a list of possibilities is generated that reflects all of the input. Next, participants vote on their top three. The list should get narrowed down to 5-7 briefly stated items. The

ACTIVITY 10: Stress Prevention and Management *(Continued)*

trainer then asks "Is there anything on this list that anyone can not live with?" Later, the list is written up and posted prominently at program offices. At meetings, groups can check back with how they are doing. A more formal evaluation can provide the basis for future team building interventions.

7. ***Self-Awareness Exercises:*** The following self-awareness exercises can be incorporated at different points in the training or as a part of in-service training.

   A. Invite participants to complete the questionnaire on Handout #7. Responses can be shared in small groups with immediate coworkers or in work units. This can be informative for supervisors to facilitate with their employees.

   B. In groups of 10-15 participants, facilitate discussions of question #2, "What are (or do you expect to be) the most stressful and the most rewarding aspects of doing disaster work?" The leader respectfully listens and paraphrases as participants share their responses, normalizing and describing common themes. Topics that might be addressed are: motivations for helping, personal prejudices or stereotypes, discomfort with intense emotions, feelings of personal or professional inadequacy, difficulties with the "helper-helpee" relationship, feelings associated with setting limits, or feeling powerless to "make enough of a difference." Some of these topics may not be relevant at this point in the program, but will inevitably surface.

8. ***Stress Reduction Exercises:*** The following stress reduction exercises can also be incorporated at different points in the training.

   A. Invite the group to stand and stretch, reaching hands toward the ceiling and breathing deeply with each stretch.

   B. Facilitate guided imagery process, with participants' eyes closed, seated comfortably, dim lights, deep breathing, physical relaxation and visualization of a personal and peaceful place.

   C. Encourage participants to take a quiet fifteen-minute break by themselves. Participants might walk outside—noticing vegetation, smells, etc., or sit and read or write, or close their eyes and meditate. Suggest that the group maintain silence during the break as an experiment.

ACTIVITY 10: Stress Prevention and Management *(Continued)*

D. As a "homework" exercise, encourage participants to do one "self-care" activity. This could be exercising, reading a book, taking a bath, writing in a journal, doing yoga, working in the yard, etc. The next morning in class, invite participants to share what they did. Again, positively respond to participants' efforts.

ACTIVITY 11

PROGRAM IMPLEMENTATION

Topics Covered

- Program goals and structure
- CMHS Program Guidance publications
- Data collection and reporting

Objectives

1. To orient staff to program service priorities, organizational structure and management plan for the program
2. To review and discuss CMHS Program Guidance publications as they pertain to the current disaster program
3. To review all program forms for data collection to assure consistency in reporting
4. To describe program reporting requirements for services and expenditures and responsibilities of staff

Time Required

1.5 hours

Materials Required

- *Handouts (program goals, organizational structure, roles and responsibilities of each job in program, CMHS Program Guidance publications, data collections forms, schedule for meetings, timeline for program reports, etc.)*

Procedures

1. ***Program Structure and Goals:*** Program administrator presents content described above to staff. Trainer may be able to assist with explaining program elements and why they are important (e.g. clarification of Program Guidance, avoiding data collection problems).
2. ***Breakout for Supervisors:*** If there are several geographically dispersed "program units," with supervisors for each subgroup, these groups might each convene at this time to discuss some of the above issues. The supervisors may want to discuss operational and logistical issues.
3. ***Team Building:*** Team building exercises that were described in Activity 10 might be appropriate here.
4. ***Course Wrap-up and Evaluation***

Overheads

Listing of Overheads:

Overhead #1: **Definition of Disaster**

Overhead #2: **Characteristics of Disasters**

Overhead #3: **Types of Disasters**

Overhead #4: **Phases of Disaster Reactions**

Overhead #5: **Psychological Reactions to Disaster**

Overhead #6: **Physical Reactions**

Overhead #7: **Emotional Reactions**

Overhead #8: **Cognitive Reactions**

Overhead #9: **Behavioral Reactions**

Overhead #10: **Chronic Stressors in Disaster**

Overhead #11: **Effects of Long-term Disaster Stress**

Overhead #12: **Key Concepts**

Overhead #13: **Disaster Mental Health Interventions**

Overhead #14: **Post-Disaster Mental Health Interventions**

Overhead #15: **Brief Trauma Intervention**

Overhead #16: **Preschool-age Children's Reactions**

Overhead #17: **School-age Children's Reactions**

Overhead #18: **Pre-adolescents and Adolescents**

Overhead #19: **Risk Factors for Children**

Overhead #20: **Psychological Tasks for Recovery**

Overhead #21: **Stressors in Disaster Work**

Overhead #22: **Stress Basics**

Overhead #23: **Organizational Approaches**

Overhead #24: **Individual Approaches**

DEFINITION OF DISASTER

A disaster is an occurrence such as a hurricane, tornado, flood, earthquake, explosion, hazardous materials accident, war, transportation accident, fire, famine, or epidemic that causes human suffering or creates collective human need that requires assistance to alleviate.

OVERHEAD #1

CHARACTERISTICS OF DISASTERS

- Natural vs. human-caused
- Degree of personal impact
- Size and scope
- Visible impact/low point
- Probability of recurrence

OVERHEAD #2

TYPES OF DISASTERS

- Natural
- Technological
- Health
- Social

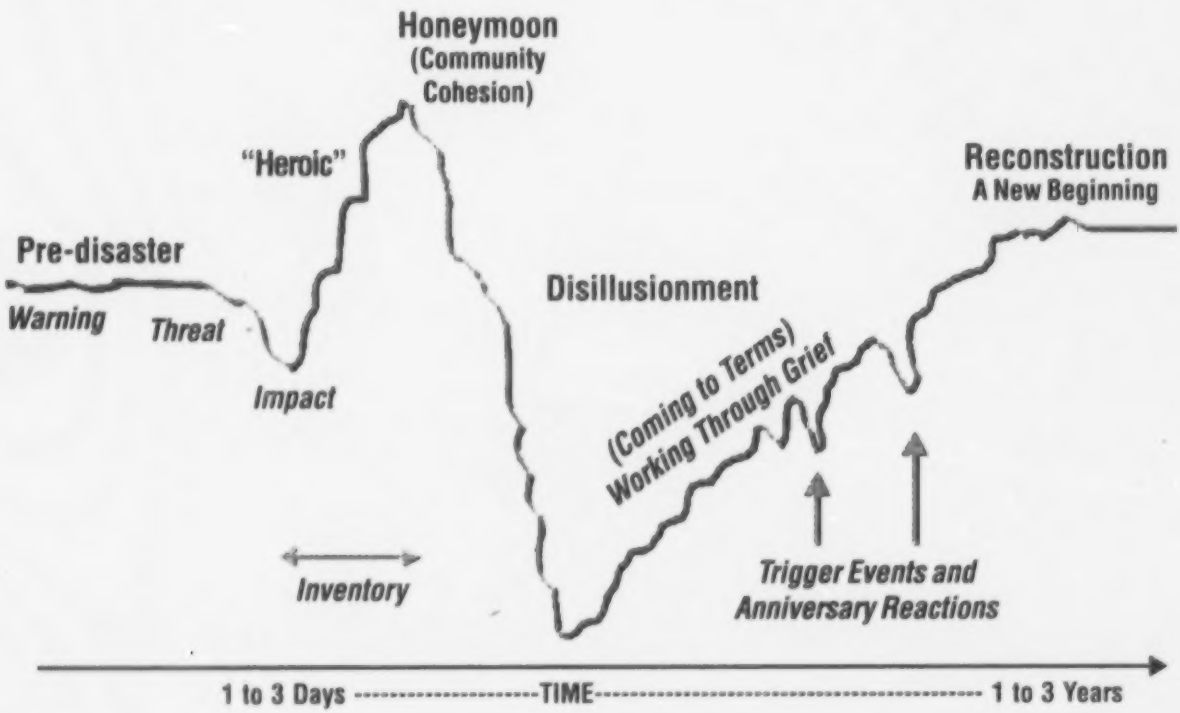
OVERHEAD #3

PHASES OF DISASTER REACTIONS

- Warning of Threat
- Impact
- Rescue or Heroic
- Remedy or Honeymoon
- Inventory
- Disillusionment
- Reconstruction and Recovery

OVERHEAD #4

PSYCHOLOGICAL REACTIONS TO DISASTER



Source: Zunin/Meyers

OVERHEAD #5

PHYSICAL REACTIONS

- Fatigue, exhaustion
- Gastrointestinal distress
- Appetite change
- Tightening in throat, chest, or stomach
- Worsening of chronic conditions
- Somatic complaints

OVERHEAD #6

EMOTIONAL REACTIONS

- Depression, sadness
- Irritability, anger, resentment
- Anxiety, fear
- Despair, hopelessness
- Guilt, self-doubt
- Unpredictable mood swings

OVERHEAD #7

COGNITIVE REACTIONS

- Confusion, disorientation
- Recurring dreams or nightmares
- Preoccupation with disaster
- Trouble concentrating or remembering things
- Difficulty making decisions
- Questioning spiritual beliefs

OVERHEAD #8

BEHAVIORAL REACTIONS

- Sleep problems
- Crying easily
- Avoiding reminders
- Excessive activity level
- Increased conflicts with family
- Hypervigilance, startle reactions
- Isolation or social withdrawal

OVERHEAD #9

CHRONIC STRESSORS IN DISASTER

- Family disruption
- Work overload
- Gender differences
- Bureaucratic hassles
- Financial strain

OVERHEAD #10

EFFECTS OF LONG-TERM DISASTER STRESS

- Anxiety and vigilance
- Anger, resentment and conflict
- Uncertainty about the future
- Prolonged mourning of losses
- Diminished problem-solving
- Isolation and hopelessness
- Health problems
- Physical and mental exhaustion
- Lifestyle changes

OVERHEAD #11

KEY CONCEPTS

- Normal reactions to abnormal situation
- Avoid "mental health" terms and labels
- Assistance is practical
- Assume competence
- Focus on strengths and potentials
- Encourage use of support network
- Active, community fit
- Innovative in helping

OVERHEAD #12

DISASTER MENTAL HEALTH INTERVENTIONS

- Rapid assessment and triage
- Crisis intervention
- Supportive listening
- Problem-solving immediate issues
- Education about disaster stress
- Debriefing and community meetings
- Information and referral

OVERHEAD #13

POST-DISASTER MENTAL HEALTH INTERVENTIONS

- Casefinding
- Letters and phone calls
- Community Outreach
- Brief counseling (individual and group)
- Case management
- Public education through media
- Information and referral

OVERHEAD #14

BRIEF TRAUMA INTERVENTION

- Fact Phase
- Thought Phase
- Reaction and Feelings Phase
- Education Phase
- Action/Re-entry Phase

OVERHEAD #15

PRESCHOOL-AGE CHILDREN'S REACTIONS

- Sleep problems, nightmares
- Separation anxiety
- Fearfulness
- Clinging
- Regression
- Repetitive play

OVERHEAD #16

SCHOOL-AGE CHILDREN'S REACTIONS

- Sleep problems, nightmares
- Fears about safety
- Preoccupation with disaster
- Physical complaints
- Depression, guilt
- Angry outbursts
- School performance decline
- Withdrawal from peers

OVERHEAD #17

PRE-ADOLESCENTS AND ADOLESCENTS

- Sleep problems
- Physical complaints
- Depression, guilt
- Withdrawal, isolation
- Aggressive behavior
- Decline at school
- Risk-taking behavior

OVERHEAD #18

RISK FACTORS FOR CHILDREN

- Death or serious injury of family member or close friend
- Witnessing grotesque destruction
- Exposure to life threat
- Separation from parents
- High level of family stress
- Recent stressful life events
- Prior functioning problems

OVERHEAD #19

PSYCHOLOGICAL TASKS FOR RECOVERY

- Acceptance of the disaster and losses
- Identification, labeling, and expression of emotions
- Regaining sense of mastery and control
- Resumption of age-appropriate roles and activities

(Pynoos & Nader, 1988)

OVERHEAD #20

STRESSORS IN DISASTER WORK

- Event-related
- Occupational
- Organizational

OVERHEAD #21

STRESS BASICS

Stress is:

- Normal
- Necessary
- Productive *and* destructive
- Acute and delayed
- Cumulative
- Identifiable
- Preventable and manageable

OVERHEAD #22

ORGANIZATIONAL APPROACHES

- Effective management structure and leadership
- Clear purpose and goals
- Functionally defined roles
- Team support
- Plan for stress management

OVERHEAD #23

INDIVIDUAL APPROACHES

- Management of workload
- Balanced lifestyle
- Stress reduction strategies
- Self-awareness

OVERHEAD #24

Handouts

Listing of Handouts:

Handout #1: **Disaster Mental Health Course Objectives**

Handout #2: **Age-Specific Interventions for Children in Disaster**

Handout #3: **Special Concerns of Older Adults in Disaster**

Handout #4: **Cultural Sensitivity and Disaster**

Handout #5: **Planning Workgroup**

Handout #6: **Common Disaster Worker Stress Reactions**

Handout #7: **Professional Self-Care**

Disaster Mental Health Course Objectives

1. Understand human behavior in disaster, including factors affecting individual's response to disaster, phases of disaster, "at-risk" groups, concepts of loss and grief, postdisaster stress, and the disaster recovery process.

2. Understand the organizational aspects of disaster response and recovery, including key roles, responsibilities, and resources; local, State, Federal, and voluntary agency programs; and how to link disaster survivors with appropriate resources and services.

3. Understand the key concepts and principles of disaster mental health, including how disaster mental health services differ from traditional psychotherapy; the spectrum and design of mental health programs needed in disaster; and appropriate sites for delivery of mental health services.

4. Understand how to intervene effectively with special populations in disaster, including children, older adults, people with disabilities, ethnic and cultural groups indigenous to the area, and the disenfranchised or people living in poverty with few resources.

5. Provide appropriate mental health assistance to survivors and workers in community settings, with emphasis on crisis intervention, brief treatment, post-traumatic stress strategies, age-appropriate child interventions, debriefing, group counseling, support groups, and stress management techniques.

6. Provide mental health services at the community level, with emphasis on casefinding, outreach, mental health education, public education, consultation, community organization, and use of the media.

7. Understand the stress inherent in disaster work and recognize and manage that stress for themselves and with other workers.

(CMHS, 1994)

Age-Specific Interventions for Children in Disaster

Age Group	*At Home*	*At School or Other Ogranization for Children*
PRE-SCHOOLERS	- Maintain family routines - Give extra physical comfort and reassurance - Avoid unnecessary separations - Permit child to sleep in parents' room temporarily - Encourage expression of feelings through play - Monitor media exposure to disaster trauma - Develop disaster safety plan - Draw expressive pictures	- Tell stories of disaster and recovery - Use coloring books on disaster - Read books on disaster and loss - Use dolls, puppets, toys, blocks for reenactment play - Facilitate group games - Talk about disaster safety and self protection - Absenteeism outreach to families and children* - Teachers, school nurses, and providers identify stressed children for assessment and referral* - In-service training on children and disaster* - School-based crisis hotline* - Provide educational brochure for parents* - Encouragement to eventually resume normal roles as students*
ELEMENTARY AGE CHILDREN	- Give additional attention and consideration - Set gentle but firm limits for acting out behavior - Listen to child's repeated telling of disaster experience - Encourage verbal and play expression of thoughts and feelings - Provide structured but undemanding home chores and rehabilitation activities - Rehearse safety measures for future disasters	- Free drawing after discussion of disaster - Free writing after discussion of disaster, complete a sentence exercise - Tell stories of disaster and recovery - Read books on disaster and loss - Role-play games about disaster - Create a play about disaster - School study or science projects to increase understanding and mastery - Talk about disaster safety, family protection, family preparedness* - Teach calming techniques (i.e., deep breathing, visualization)* - Field visit to disaster-affected area* - Small group or individual interventions for high risk children* - Group "debriefing" discussion to express and normalize reactions, correct misinformation, and enhance coping and peer support*

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Age-Specific Interventions for Children in Disaster (Continued)

Age Group	*At Home*	*At School or Other Ogranization for Children*
PRE-ADOLESCENTS AND ADOLESCENTS	- Give additional attention and consideration - Encourage discussion of disaster experiences with peers, significant adults - Avoid insistence on discussion of feelings with parents - Suggest involvement with community recovery work - Encourage physical activities - Encourage resumption of regular social and recreational activities - Rehearse family safety measures for future disasters	- *All interventions starred above apply. - School programs for assisting community with recovery, helping others - Projects to commemorate and memorialize disaster gains and losses - Encourage discussion of disaster losses with peers and adults - Resume sports, club, and social activities when appropriate

Special Concerns of Older Adults in Disaster

Reluctance to evacuate – Research shows that older adults are less likely to heed warnings, may delay evacuation, or resist leaving their homes during disasters. Disaster planning and preparedness is especially critical with this group.

Vulnerable housing – Due to limited income, older adults tend to live in dwellings that are susceptible to disaster hazards due to the location and age of buildings.

Fear of institutionalization – Many older adults fear that if their diminished physical or emotional capabilities are revealed, they will risk loss of independence or institutionalization. They may under-report the full extent of their problems and needs.

Multiple losses – An older person may have lost their income, job, home, loved ones, and/or physical capabilities prior to the disaster. For some, these prior losses may build coping strength and resilience. For others, these losses compound each other. Disasters sometimes provide a final blow that makes recovery especially difficult.

Significance of losses – As a result of a disaster, irreplaceable possessions such as photograph albums, mementos, valued items, or sacred objects passed on through generations may be destroyed. Pets or gardens developed over years may be lost. The special meaning of these losses must be recognized to assist with grieving.

Sensory deprivation – An older person's sense of smell, touch, vision, and hearing may be less acute than the general population. As a result, they may feel especially anxious about leaving familiar surroundings. They may not be able to hear what is said in a noisy environment or may be more apt to eat spoiled food.

Chronic health conditions – Higher percentages of older persons have chronic illnesses that may worsen with the stress of a disaster, particularly when recovery extends over months. Arthritis may prevent an older person from standing in line for long periods of time. Problems with thinking and memory may affect the person's ability to remember or process information.

Medications – Older adults are more likely to be taking medications that need to be replaced quickly following disaster. Medications may cause problems with confusion or memory, or cause a greater susceptibility to problems such as dehydration.

Hyper/hypothermia vulnerability – Older persons are often more susceptible to the effects of heat and cold. This becomes critical in disasters when furnaces and air conditioning may be unavailable.

Transfer and relocation trauma – Frail adults who are dislocated without use of proper procedures may suffer illness or even death. Relocation to unfamiliar surroundings and loss of community may result in depression and disorientation.

Delayed response syndromes – Older persons may not react as fast to a situation as younger persons. In disasters, this may mean that deadlines for applications or eligibility timelines may need to be extended.

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Mobility impairment or limitation – Older persons may not be able to use automobiles or have access to public or private transportation. This may limit the opportunity to relocate, go to shelters, Disaster Recovery Centers, or to obtain food, water, or medications when necessary.

Financial limitations – Because many older adults live on fixed and limited incomes, they can't take out a loan to fully repair their homes. They are unable to "start over" due to lack of money and time, as is more possible for younger people.

Literacy – Older persons have lower educational levels than the general population. This may present difficulties in completion of applications or understanding directions. Public information targeting this group must be disseminated in multiple ways, including by non-written means.

Isolation – Some older adults have limited social support systems and are not associated with local senior centers or churches. Their isolation may contribute to not learning about available resources. They may not have access to help with clean-up or repairs. Disaster outreach efforts should prioritize reaching these individuals.

Crime victimization – Con artists target older people, particularly after a disaster. These issues need to be addressed in shelters, housing arrangements, and when contractors are being selected to repair homes.

Bureaucracy unfamiliarity – Older adults often have not had experience working through bureaucratic systems. This is especially true for those who had a spouse who dealt with these areas.

Welfare stigma – Many older persons will not use services that have the connotation of being welfare or a "handout." They may need to be convinced that disaster services are available as a government service that their taxes have purchased.

Mental health stigma – Older persons may feel ashamed because they experience mental health problems, or they may be unfamiliar with counseling as a form of support. Psychological stress may be manifested in physical symptoms, which some find as more acceptable. Mental health services should emphasize "support," "talking," and "assistance with resources," and de-emphasize diagnosis or psychopathology.

(Deborah J. DeWolfe, Ph.D., 1995)

Resource Materials

Diane Myers, R.N., M.S.N. *Older Adults' Reactions to Disaster Handout.* 1990.

U.S. Department of Health and Human Services. *Action Plan of the Administration on Aging to Strengthen the Disaster Response Capacity to Serve Older People,* 1994.

Cultural Sensitivity and Disaster

Disaster mental health recovery programs must respond specifically and sensitively to the various cultural groups affected by a disaster. In many disasters, ethnic and racial minority groups may be especially hard hit because of socioeconomic conditions which force the community to live in low income, sub-standard housing that is particularly vulnerable to destruction. Language barriers, suspicion of governmental programs due to prior experiences, rejection of outside interference or assistance, and differing cultural values often contribute to disaster outreach programs' difficulty in establishing access and acceptance.

Cultural diversity includes social class, gender, race, and ethnicity. Each family or individual receiving disaster mental health services should be viewed within the context of their cultural/ethnic/racial group and their experience of being a part of that group. The degree and nature of acculturation is relevant, in that bicultural influences are manifested by variation within each group.

To be culturally sensitive and provide appropriate services, disaster mental health professionals must be aware of their own values, attitudes, and prejudices (we *all* have them), be committed to learning about cultural differences, and be flexible, creative, and respectful in our intervention and outreach approaches.

Some Considerations When Establishing Contact With Ethnic Groups

Language/degree of fluency in English and literacy – Program cultural sensitivity is conveyed when information is translated into primary languages and/or available in non-written forms. When English is a person's second language, emotions are frequently experienced and expressed in their language of origin. Use of trained translators, especially with mental health backgrounds, is preferable to family or neighbors because of issues of privacy and confidentiality.

Immigration experience and status – The number of generations and years in the U.S., degree of acculturation, and citizenship status are relevant to consider when defining outreach strategies. Also, war, living conditions, and trauma in the country of origin as well as conditions of immigration may impact coping with the current disaster.

Family values – Determine who is included in the "family." Often, elders and extended family members are considered part of the family unit and form the primary avenue of support. Learn who the family decision-makers are, what the relative roles of women and men, parents and children, and the older generation are. Establish who should be included in outreach or "counseling" sessions.

Cultural values and traditions – Cultural groups have considerable variation regarding views of loss, death, grieving, property, home, rebuilding, religion, spiritual practices, mental health, healers, and helping. The disaster itself may be viewed as punishment, an act of God or other deity, or the result of another event or action.

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Suggestions for Intervention

- Learn from local leaders, social service workers, and community members from the cultural group about values, family norms, traditions, community politics, etc.
- Involve mental health staff and community outreach workers who are bilingual and bicultural whenever possible. Involve trusted community members to enhance credibility.
- Allow time and devote energy to gaining acceptance, be wary of aligning your efforts with agency/organizations that are mistrusted by the communities you're trying to reach. Take advantage of association with valued and accepted organizations.
- Be dependable, non-judgmental, genuine, respectful, well-informed, and credible to the community. Listen for verbal and non-verbal cues and modify efforts accordingly.
- Determine most appropriate and acceptable ways to introduce yourself and define your program and services to be culturally sensitive.
- Recognize cultural variation in expression of emotions, manifestation, and description of psychological symptoms, mental health problems, and view of "counseling."
- Provide community education information in multiple languages and via radio, TV, and church announcements if there is low literacy level.
- Focus on problem-solving and concrete solutions. Be action-oriented and empower clients through education and skill-building.
- Assist in eliminating barriers to help: interpret facts, policies, and procedures, provide advocacy and resource assistance in dealing with barriers.

(Deborah J. DeWolfe, Ph.D., 1993)

Resource Materials

Diane Myers, R.N., M.S.N. and Josie Romero, L.C.S.W. Task Force on the Delivery of Services to Ethnic Minority Populations, American Psychological Association. *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations.* 1990.

Bolin, R. C. & Bolton, P. *Race, Religion and Ethnicity in Disaster Recovery.* Institute of Behavioral Science, University of Colorado, 1986.

Planning Workgroup

Discuss the needs of your population group over time. Brainstorm a range of intervention possibilities that serve your group directly as well as secondary groups including gatekeepers.

Have a group recorder write down (legibly!) responses to the following questions so that they can be reported back to the larger group and compiled into a program-wide resource directory.

1. What are the points of contact to reach your group (e.g., churches, schools, clinics, etc.)?

2. Who are the key people, group leaders, and gatekeepers?

3. What significant events or milestones do you anticipate over time?

4. What programs or outreach efforts *have* been effective so far?

5. Brainstorm program ideas and outreach strategies. Consider #1, 2 and 3 as you generate possibilities.

Common Disaster Worker Stress Reactions

Psychological and Emotional

- Feeling heroic, invulnerable, euphoric
- Denial
- Anxiety and fear
- Worry about safety of self and others
- Anger
- Irritability
- Restlessness
- Sadness, grief, depression, moodiness
- Distressing dreams
- Guilt or "survivor guilt"
- Feeling overwhelmed, hopeless
- Feeling isolated, lost, or abandoned
- Apathy
- Identification with survivors

Cognitive

- Memory problems
- Disorientation
- Confusion
- Slowness of thinking and comprehension
- Difficulty calculating, setting priorities, making decisions
- Poor concentration
- Limited attention span
- Loss of objectivity
- Unable to stop thinking about the disaster
- Blaming

Behavioral

- Change in activity
- Decreased efficiency and effectiveness
- Difficulty communicating
- Increased sense of humor
- Outbursts of anger, frequent arguments
- Inability to rest or "letdown"
- Change in eating habits
- Change in sleeping patterns
- Change in patterns of intimacy, sexuality
- Change in job performance
- Periods of crying
- Increased use of alcohol, tobacco, or drugs
- Social withdrawal, silence
- Vigilance about safety or environment
- Proneness to accidents
- Avoidance of activities or places that trigger memories

Physical

- Increased heartbeat, respiration
- Increased blood pressure
- Upset stomach, nausea, diarrhea
- Change in appetite, weight loss or gain
- Sweating or chills
- Tremors (hands, lips)
- Muscle twitching
- "Muffled" hearing
- Tunnel vision
- Feeling uncoordinated
- Lower back pain
- Feeling a "lump in the throat"
- Exaggerated startle reaction
- Fatigue
- Menstrual cycle changes
- Change in sexual desire
- Decreased resistance to infection
- Flare-up of allergies and arthritis
- Hair loss
- Headaches
- Soreness in muscles

(CMHS, 1994)

Professional Self-Care

1. What do you value most about doing disaster mental health work?

   _____

   _____

2. What are (or do you expect to be) the most stressful and the most rewarding aspects of disaster work?

   _____

   _____

3. How do you know when you are stressed?

   _____

   _____

4. How might your co-workers know when you are stressed?

   _____

   _____

5. What can others do for you when you are stressed?

   _____

   _____

6. What can you do for yourself?

   _____

   _____

Remember: *You are a far less effective helper of others when you are not taking care of yourself.*

Good teamwork means encouraging each other to manage stress.

(Deborah J. DeWolfe, Ph.D., 1996)

Videotapes

Beyond the Ashes. City of Berkeley Mental Health Division, California Department of Mental Health, 1992.

Disaster Psychology: Victim Response. Catonsville, MD: Instructional Media Resources, University of Maryland, Baltimore County, 1985.

FEMA funded the videotape projects listed below through the Crisis Counseling Program. Copies are available at no charge from the Center for Mental Health Services, National Mental Health Services Knowledge Exchange Network, P.O. Box 42490, Washington, DC 20015 or by contacting any of the following:

Toll-free information line: 1-800-789-2647
CMHS Electronic Bulletin Board: 1-800-790-2647
TTY: 301-443-9006
FAX: 301-984-8796

Children and Trauma: The School's Response. Alameda County Department of Mental Health, Santa Cruz County Department of Mental Health, and California Department of Mental Health, 1991.

Faces in the Fire: One Year Later. Santa Barbara County Department of Mental Health, California Department of Mental Health, 1991.

Hope and Remembrance. Texas Department of Mental Health, 1997.

Hurricane Blues. South Carolina Department of Mental Health, 1990.

Voices of Wisdom: Seniors Cope With Disaster. San Bernardino County Department of Mental Health and the California State Department of Mental Health, 1992. (Available in Spanish.)

References and Recommended Reading

Center for Mental Health Services. *Disaster Response and Recovery: A Handbook for Mental Health Professionals.* Washington, D.C.: U.S. Department of Health and Human Services, Publication No. (SMA) 94-3010, 1994.

Center for Mental Health Services. *Manual for Child Health Workers in Major Disaster.* Washington, D.C.: U.S. Department of Health and Human Services; Publication No. (ADM) 86-1070. (Rev. ed. in press.)

Center for Mental Health Services. *Psychosocial Issues for Older Adults in Disasters.* Washington, D.C.: U.S. Department of Health and Human Services, Publication No. (SMA) 99-3323, 1999.

Federal Emergency Management Agency. *How to Help Children After a Disaster: A Guidebook for Teachers.* Washington, D.C.: FEMA Publication No. 219, 1991.

Federal Emergency Management Agency. *School Intervention Following a Critical Incident.* (Project COPE). Washington, D.C.: FEMA Publication No. 220, 1991.

LaGreca, A. M., Vernberg, E. M., Silverman, W. K., Vogel, A. L. & Prinstein, M. J. *Helping Children Prepare for and Cope with Natural Disasters: A Manual for Professionals Working with Elementary School Children.* BellSouth Corporation, 1994. (To obtain copies: Contact Dr. LaGreca, Department of Psychology, University of Miami, P.O. Box 248185, Coral Gables, FL 33124.)

Mitchell, J. & Bray, G. *Emergency Services Stress: Guidelines for Preserving the Health and Careers of Emergency Services Personnel.* New Jersey: Prentice-Hall, 1990.

Pynoos, R. S. & Nader, K. *Psychological first aid and treatment approach to children exposed to community violence: Research implications. Journal of Traumatic Stress,* 1988, 1, 445-473.

Vernberg, E. M. & Vogel, J. M. "Interventions with children after disasters." *Journal of Clinical and Child Psychology,* 1993, 22(4), 485-498.

Vogel, J. M. & Vernberg, E. M. "Children's psychological responses to disasters." *Journal of Clinical and Child Psychology,* 1993, 22(4), 464-484.

SECTION 7

Additional Training Needs and Options

Crisis counseling staff training serves multiple functions. In the immediate phase of disaster response, training quickly provides necessary logistical and intervention information. This training is action-oriented, brief, and repeated as new mental health staff join the operation. Section 5 describes this Initial Start-up Training. In addition, Chapter Two in *Disaster Response and Recovery: A Handbook for Mental Health Professionals* provides an excellent overview of issues pertinent to selecting and training disaster mental health staff (CMHS, 1994).

Several months after the disaster a stable group of workers, who will remain through the duration of the program, have been hired. The crisis counseling project's organizational structure and procedures have become further defined and resemble that of an established program, as opposed to a rapid response mobilization. The comprehensive disaster mental health training presented in Section 6 may be conducted at this point in the implementation process, or may have been offered earlier. This comprehensive training provides extensive disaster mental health background and intervention information, and also addresses team development and worker stress management. During the remaining months of the program in-service continuing education is essential, as new training needs are identified and phase-related issues emerge.

Paraprofessional "peer counselors" are valuable members of disaster mental health recovery programs. While bringing varied and salient life experiences to their disaster work, paraprofessionals also need additional training on counseling skills, mental health assessment and referral, and ethical issues.

This section addresses additional training needs beyond the comprehensive training outlined in Section 6. Training options included in this section are:

- Training for Paraprofessional Staff
- Training for Human Service Workers
- Topics and Considerations for In-Service Training

Training for Paraprofessional Staff

Paraprofessional counseling staff may be recruited from existing community programs, such as, senior outreach services, church-sponsored programs, ethnic group-oriented service programs, American Red Cross volunteers, or farm advocacy volunteers. These workers should reflect the demographic characteristics and ethnic and cultural groups present in the disaster-affected community. Solid interpersonal communication skills, the ability to work cooperatively with others, the psychological capacity to help others without judgment, and the ability to maintain confidentiality are desired qualities for paraprofessional counselors.

When paraprofessional staff have participated in a training session on counseling skills prior to the program's comprehensive disaster mental health training, they can engage with the disaster information from a broader context and foundation. An initial two-day training course with regular weekly or bi-weekly continuing education and supervision sessions is suggested.

The following topics are recommended for inclusion in training for paraprofessional staff:

Counseling Skill Development

1. ***Active Listening*** – Using nonverbal cues, giving minimal encouragements (nods and "uh-huhs"), conveying empathy, paraphrasing, reflecting feelings, summarizing, differentiating content, and feelings.
2. ***Asking Questions*** – Interviewing techniques, asking open and closed questions, focusing with questions, avoiding using questions to give advice or make judgments.
3. ***Providing Support and Encouragement*** – Establishing rapport, empowering the survivor, giving positive feedback about coping strengths, offering suggestions, avoiding communication blocks, and unhelpful phrases.

Counseling Interventions

1. ***Crisis Intervention*** – Assessing capacity to live independently, evaluating suicide and dangerousness risk, giving reassurance, building hope, protocols for immediate response, procedures for consultation, referral, and follow-up.
2. ***Listening to Disaster Experiences*** – Prompting telling (and retelling) of disaster stories, exploring feelings and reactions, educating about disaster stress, and healthful coping strategies.

3. ***Problem-solving*** – Identifying and defining the problem, exploring feelings, brainstorming solutions and resources, setting doable goals, taking action, and evaluating results.

Self-Awareness

1. ***Motivations for Helping*** – Exploring personal experiences, understanding helping relationships vs. friendships, over identifying with survivors.
2. ***Awareness of Feelings*** – Identifying and articulating feelings, becoming familiar with range of "feeling words," and tolerating expressions of "uncomfortable" emotions.
3. ***Stereotypes and Values*** – Exploring personal biases and prejudices, avoiding judgmental attitudes, and promoting respect for differences.

Assessment of Mental Health and Other Problems

1. ***Basic overview of depression, anxiety, post-traumatic stress disorder, alcohol and drug abuse, child and elder abuse, mental illness, cognitive impairment/dementia*** – Symptom recognition, initial assessment strategies, procedures for consultation, referral, and follow-up.

Legal, Ethical and Program Considerations

1. Confidentiality, state law and reporting requirements, and procedures;
2. Record keeping, program reporting, and monitoring;
3. Boundaries of relationship with clients;
4. Stress prevention and management (Section 4); and
5. Consultation, supervision, and continuing education.

Paraprofessional staff training emphasizes that the helping person is in a privileged position. Helping someone in need implies a sharing of problems, concerns, and anxieties—sometimes with very personal details. This special sharing cannot be done without a sense of trust, a trust which is built upon mutual respect and includes the explicit understanding that all discussions are confidential and private. This mutual respect also involves acceptance of the survivor's experience, thoughts, and feelings—judging or moralizing or telling the survivor how he or she should feel only alienates and undermines the helping relationship.

Counseling skill building through role-playing, observing role models, discussing case examples, and giving and receiving feedback helps paraprofessional staff gain competency. Having clear guidelines for assessment and referral helps counselors to function within the boundaries of their training. Training facilitators must be adept at identifying and processing feelings, evaluating and promoting counseling skill development, and providing clear and concise procedures for challenging situations. Training for paraprofessional counselors should be ongoing and integrated with case consultation and practicing counseling skills.

Training for Human Service Workers

Human service workers may be directly involved in the disaster relief effort through Federal, State or local agencies, emergency services, law enforcement, the American Red Cross, the Salvation Army, or local churches. Most will benefit from focused training on disaster mental health issues geared to their respective roles. The *Field Manual for Mental Health and Human Service Workers in Major Disasters* (CMHS, Rev. ed. in press) that accompanies this training manual is an excellent resource to provide as an adjunct to training. Developing a good working relationship with these entities for mutual referrals is a valuable by-product of such training.

This training can be accomplished in several ways. Representatives from the various agencies and organizations may attend the comprehensive disaster mental health course. When this occurs, the trainer should rearrange the training schedule so that representatives from outside agencies attend for the first day, or possibly mornings, only. The training agenda should efficiently address these representatives' needs, while not compromise meeting the diverse training needs of the crisis counseling staff.

Another alternative is providing on-site disaster mental health training with each group. The training can then more specifically address each group's needs. Activities, overheads, and handouts can be used from the comprehensive training as needed. However, losing the exposure to the entire crisis counseling staff and their enthusiastic efforts is a trade-off.

Disaster relief and recovery workers comprise one type of human service worker involved with survivors. Other disaster-related service workers encounter survivors in the course of conducting business or providing services. Examples are home health nurses, public assistance workers, school personnel, building permit inspectors, church staff, primary health care providers, or hairdressers. Disaster mental health training and educational materials can assist these individuals to better serve disaster survivors and to refer those in need to the crisis counseling

project. Also, these individuals can distribute disaster stress and coping brochures to survivors.

The program may establish a "task group" to design outreach strategies, training presentations, and educational materials for these collateral providers and human service workers in the community. Since experience has shown that many survivors are more likely to talk with their physician, pastor or someone known to them before talking with a "counselor," outreach and education with these groups is extremely important.

Topics and Considerations for In-Service Training

The comprehensive training course provides staff with a good introduction to disaster mental health. As staff engage with the disaster-affected communities over time, additional training needs become apparent. These identified training needs may involve particular population groups, current disaster recovery issues, specific mental health or substance abuse problems, or needed modifications of intervention strategies. Also, timing or phase-related topics such as anticipating the beginning of the next disaster season or the one-year anniversary of the disaster, may become relevant.

In-service training also serves the important function of bringing the staff together to strengthen group cohesion, social support, morale and creativity. The focus of the session may be tending to the emotional challenges of disaster work through personal sharing, case consultation, and problem-solving new solutions. Some of the suggestions and exercise ideas in Section 4, "Stress Prevention and Management," can be included in the training. A skilled facilitator may identify organizational issues or procedures that may be interfering with staff well being or program effectiveness.

The following are examples of in-service training topics:

- Media relations and disaster mental health community education
- Public speaking skills for disaster mental health presentations
- Stress management interventions for survivors, disaster workers, and program staff
- More extensive training on serving children, older adults, or ethnic/cultural groups in the community
- Long-term family stress issues following disaster
- Long-term disaster recovery issues and interventions
- Disaster mental health role and interventions with post-traumatic stress disorder, alcohol and drug abuse problems, or complicated bereavement

- Expressive intervention approaches (art, music, drama, writing, community projects) with adults and children
- Support groups and group dynamics
- Community organizing to address unmet disaster-related needs
- Anniversary reactions and commemorative events
- Specialized topics on survivor issues (scam contractors, resources for referral and unmet needs, permitting process, insurance, etc.)
- Specialized topics on local disaster issues (warning systems, disaster preparedness, floodplain management, seismic safety, etc.)
- Steps for program phase-down and termination
- Final celebration of program successes and lessons learned

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